

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ Registered nurse, licensed to practice in the State
- ☐ Licensed practical or vocational nurse, acting within the scope of practice under State law
- ☐ Licensed physician (M.D. or D.O.)
- ☒ Case Manager (qualifications specified in Appendix C-1/C-3)
- ☐ Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ Social Worker

Specify qualifications:

- ☐ Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- ☒ Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- ☐ Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following approval of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case

manager, integrated health care coordinator, or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations.

The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid members. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver members about services and supports that are available but may not have been identified during the service plan development process.

IME Medical Services uses the interRAI - Home Care (HC) assessment tool to determine level of care for the Elderly Waiver. The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services. This assessment tool is completed prior to the initial eligibility determination and yearly thereafter for fee-for-service (FFS) and MCO members.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service member's service plans are developed by the member, case manager or health home coordinator, and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the member. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The case manager or health home coordinator uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: For both FFS and managed care enrollees, the types of assessments used are identified in Appendix B-6-e.

The case manager or health home coordinator informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The case manager or health home coordinator will also discuss with the member the self-direction option and give the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;

- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

The case manager or health home coordinator will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a member chooses to self-direct, the member with the help of a case manager or health home coordinator identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the individual. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Services plans must:

- Reflect that the setting in which the member resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to DHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or

terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive DHS prior approval.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager or integrated health home care coordinator, and for MCO members by their respective CBCM, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the participant in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the member or other persons or significant amounts of property damage. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition providers of applicable services shall provide for emergency backup staff.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify in the service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or the member's needs change.

Personal Emergency Response and Portable Locator Services are available under the waiver and it is encouraged that this service be used as part of emergency backup plan when a scheduled support worker does not appear. Other providers may be listed on the service plan as source of back up as well. All members choosing the self-direction option will sign an individual risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. For fee-for-service members, this system assists the Medicaid Agency and the case manager and health home coordinator with tracking information, and monitoring and approving the service plan. Through ISIS case manager, or health home coordinator, authorizes service and service payments on behalf of the member. There are certain points in ISIS process that require contacting the designated DHS central office personnel. The case manager and health home coordinator are responsible for the development the service plan and the service plan is authorized through ISIS, which is the Medicaid Agency. (Refer to appendix A and H for ISIS system processes.)

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the IME website, MCO website, and/or MCO member services call center, the case manager, health home coordinator, community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with the available providers before making a selection. Members are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to members through their case manager, health home coordinator, community-based case manager, IME website, and/or MCO website. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an in-network provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs to the extent their provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24-hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. ISIS will only be utilized for fee-for-service members. Quality data for managed care members will be provided by the MCOs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):
- ☒ Medicaid agency

- ☐ Operating agency
☐ Case manager
☒ Other

Specify:

Medicaid enrolled case managers or integrated health home coordinators maintain fee-for-service member service plans. MCO community-based case managers maintain MCO member service plans.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

FFS Members

DHS is responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:

- Monitoring service utilization.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Making a face-to-face contact with the member at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member's needs the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager or integrated health home care coordinator if there are any problems with either Medicaid or non-Medicaid services. The case manager or integrated health home care coordinator will then follow up to solve any problems. Monitoring service utilization includes verifying that:

- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

HCBS specialists monitor the health and welfare, service plan implementation, and case manager or integrated health home care coordinator involvement during the home and community quality assurance review process. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCO Members

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members and choice of providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the community based case manager must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of \$315 per occurrence.

b. Monitoring Safeguards. Select one:

- ☒ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- ☐ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-a: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-c2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Medicaid contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

SP-c1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-d1: The IME will measure the # and percent of members' service plans that identify all the following elements: * amount, duration, and funding sources of all services * all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Service plans are requested from the case managers, with service provision documentation requested from providers

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Contracted Entity including MCO		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-e1: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who stated that they were a part of planning their services;

Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

FFS HCBS UNIT QA survey data and MCO IPES databases

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify:

Performance Measure:

SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.

Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; **Denominator:** The total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

FFS QA review of service plan stored in OnBase. MCOs review service plans available through their systems.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medical Services unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Medical Services unit utilized criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect case manager remediation request response is in development.

The HCBS unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCOs	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- ☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ☒ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services for members regardless of delivery (FFS members or MCO members)—the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. At the time of service plan development and/or at the member's request, the member has the option to convert the following services into an individualized self-direction budget based on services that are authorized in their service plan: (1) unskilled CDAC; (2) assistive devices; (3) HVM; (4) chore; (5) basic respite; (6) home delivered meals; (7) homemaker; (8) transportation and (9) senior companion.

CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchasing other goods and services. A member may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services.

If any of these options are elected, an Independent Support Broker (ISB) and Financial Management Service (FMS), by State administrative rule, must be involved. Two budgets will be developed as a result of the service plan development: traditional services budget (includes traditional services for which the member does not have budget or employer authority) and the individual budget (includes services and supports for which the member does have budget and employer authority).

Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community, as well as activities of daily living and incidental activities of daily living that help the member remain in their home and in their community. Self-directed Community Supports and Employment are services that support the member in developing and maintaining life and community integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an

identified need in the service plan. The item or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Members have authority over the individual authorized budget to perform the following tasks: (1) contract with entities to provide services and support; (2) determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1 (2); (3) schedule the provision for services; (4) authorize payment for waiver goods and services identified in the individual budget; and (5) reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the member as optional service components.

All members choosing CCO will work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest. Per 441 Iowa Administrative Code 78.34(13)"k," the ISB "shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member."

Members will also work with an FMS provider that will receive Medicaid funds on behalf of the member. The FMS is a Medicaid provider, and receives an electronic funds transfer (EFT) on a monthly basis for the member's monthly budget amount. The FMS is responsible for paying all employer taxes as required. Employees of the member are required to submit timecards for payment within thirty days of providing the service. The member's monthly budget includes a monthly per member, per month fee for the FMS provider, with the remainder designated for the purchase of goods and services for the member. Per 441 Iowa Administrative Code 78.34(13)"l," the FMS "shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service."

A utilization adjustment factor (UAF) is used to adjust the CCO budget to reflect statewide average cost and usage of waiver services. Annually, the Department determines the average cost for each waiver service. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This percentage is applied to the cap amount to determine the CCO "budget amount". The budget amount is the total funds available to the member in the monthly CCO budget. This UAF includes all HCBS waiver members in the calculation, not just members participating in CCO.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member, and approved by DHS prior to implementation. The good or service being saved for must be an assessed need identified in the member's service plan.

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.
Select one:

- ☐ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may

function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☒ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☒ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☒ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Assisted Living Facilities certified by the Department of Inspections and Appeals. The Department does not allow the use of self-direction services to members living in residential care facilities.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☒ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☐ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Self-direction training and outreach materials are available through the IME website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local DHS offices, the DHS website, and has been distributed to other community agencies. The member may also call IME Member Services and request to have the brochure mailed directly to them. All members must sign an

informed consent contract and a risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

The member's case manager, integrated health home care coordinator, or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the member's needs change. This results in information about member direction activities being reviewed, at least annually, with the member. This option is intended to be very flexible; members can choose this option at any time. Once given information about this option, the member can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

To give the member an opportunity to locate providers and supports, the service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Members can elect self-direction and then elect to go back to traditional services at any time. The case manager, integrated health home care coordinator, or community-based case manager is responsible for informing the member of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ The State does not provide for the direction of waiver services by a representative.
- ☒ The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The policies described in this section apply to both the fee-for-service and managed care delivery systems. Services may be self-directed by a non-legal representative freely chosen by an adult member. If the member selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years of age or older. The member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the member's file and provided to the member and their representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member.

The IME uses a quality assurance process to interview members in order to determine whether or not the representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that members' needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of members. The interview sample

selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The member's case manager, integrated health home care coordinator, or community-based case manager is responsible to assess individual needs and monitor service delivery to assure that the member's health and safety are being addressed. Case managers, integrated health home care coordinators and community-based case managers routinely review how services are being provided and monitor services to assure the member's needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the member. These quality assurance processes are subject to DHS review and approval and include, but are not limited to, monthly member interviews to assess whether a non-legal representative is working in the best interest of the member. DHS provides additional oversight in accordance with the HCBS quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Self-directed Personal Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Chore Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Senior Companion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Independant Support Brokerage Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home and Vehicle Modification	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Devices	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homemaker	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Delivered Meals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Consumer-directed attendant care - Skilled	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☒ **Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- ☐ Governmental entities
☒ Private entities

- ☐ No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☒ FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:
Financial Management Service

- ☐ FMS are provided as an administrative activity.

Provide the following information

- i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be a cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and charged by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by DHS or a financial institution chartered by the Office of the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

- ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid a monthly fee for their services.

- iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assist participant in verifying support worker citizenship status
☒ Collect and process timesheets of support workers
☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐ Other

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ Maintain a separate account for each participant's participant-directed budget
☒ Track and report participant funds, disbursements and the balance of participant funds

- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

IME provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by DHS or by a designated IME unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the IME reviews for compliance and monitors outcomes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager, integrated health care coordinator, or community-based case manager provides the waiver member with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The case manager, integrated health care coordinator, or community-based case manager also assists the member in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program conducts regular CCO webinars to provide case managers, integrated health care coordinators, community-based case managers, and ISB's with information on understanding and implementing

the CCO program. The webinars also identify self-direction issues that have been identified through quality assurance activities. All case managers, integrated health care coordinators, and community-based case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met.

- ☒ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>
Mental Health Outreach	<input type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Self-directed Personal Care	<input checked="" type="checkbox"/>
Chore Services	<input type="checkbox"/>
Personal Emergency Response or Portable Locator System	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Senior Companion	<input type="checkbox"/>
Independant Support Brokerage Service	<input checked="" type="checkbox"/>
Home and Vehicle Modification	<input type="checkbox"/>
Assisted Living	<input type="checkbox"/>
Assistive Devices	<input type="checkbox"/>
Nutritional Counseling	<input type="checkbox"/>
Consumer Directed Attendant Care-unskilled	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Consumer-directed attendant care - Skilled	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Individual Directed Goods and Services	<input checked="" type="checkbox"/>
Financial Management Service	<input checked="" type="checkbox"/>
Nursing Services	<input type="checkbox"/>
Home Health Aide Services	<input type="checkbox"/>

- ☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with the Iowa Medicaid Enterprise (IME) the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to case managers, integrated health care coordinators, community based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost effective manner.

The Quality Assurance and Technical Assistance contract is managed by an IME state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by the IME monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance and Technical Assistance Unit contract manager to make corrections and improve performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- ☒ No. Arrangements have not been made for independent advocacy.
- ☐ Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. A new service plan will be developed if the member's needs change or if they voluntarily discontinue the self-direction option. The case manager, integrated health care coordinator, or communitybased case manager will work with the member to ensure that services are in place and that service continuity is maintained.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

For fee-for-service members, case managers or integrated health care coordinators will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the case manager or integrated health care coordinator is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the case manager or integrated health care coordinator to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The case manager or integrated health care coordinator will develop a new service plan and assure alternative services are in place to maintain service.

MCOs may only initiate involuntary termination of a member's use of the self-direction option if there is evidence of Medicaid fraud or misuse of funds, or if the MCO determines there is a risk to the member's health or safety. Under these conditions, MCOs are required to submit a request to DHS for review and approval to involuntarily terminate. Requests must contain sufficient documentation regarding the rationale for termination. Upon DHS approval, MCOs must notify the member and facilitate a seamless transition to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="248"/>
Year 2	<input type="text"/>	<input type="text" value="250"/>
Year 3	<input type="text"/>	<input type="text" value="252"/>
Year 4	<input type="text"/>	<input type="text" value="254"/>
Year 5	<input type="text"/>	<input type="text" value="256"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:**

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member. The State pays for the first background check of workers who provide waiver services to fee-for-service members. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide waiver services to members.

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☒ **Determine staff wages and benefits subject to State limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☒ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the State's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager, integrated health care coordinator, or community based case manager and member work together to detail the tasks and goals for the provider. After service provision, the provider submits a claim to the member's plan, where the claim is adjudicated in accordance with IME protocols.

Under the self-direction option, a member is not limited to the providers who have enrolled with Iowa Medicaid. The member is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Members create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. Members determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the member. Claims are submitted to the FMS for processing for payment.

Case managers, integrated health care coordinators, and community based case managers remain responsible to ensure the programs and budgets are utilized appropriately. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to DHS review and approval.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the level of care assessment and need of the member. If a member has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of service that was authorized for those services under the traditional service plan. The level of needs are determined by the level of care determination made by IME MSU; the supports needed and the amount of supports needed are determined through an assessment reviewed by the case manager, integrated health care coordinator, or community based

case manager prior to the member selecting the self-direction option. Members who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the member can choose to self-direct services not provided by the facility (i.e., vehicle modification) or can choose another provider for services that are optional from the facility (i.e., meals or housekeeping).

Historically, members do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all members enrolled in that particular waiver who have accessed that particular service. The utilization factor is not based upon individual member usage, but on historical percentage usage of authorized services by all members enrolled in the waiver who have accessed that particular service. A member new to the waiver, or new to self-direction, would have the same utilization factor applied as all other waiver members who are self-directing services. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver members choosing the self-direction option. Members are notified of the budget methodology and limits at the time they receive the CCO Booklet, during their service plan is development and by the Independent Support Broker hired to assist the individual to develop the budget. The individual budget methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition, this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their community based case managers and member communication materials.

The following is an example of how an individual budget is determined:

A member has a need for a particular service. On their traditional service plan they are authorized 10 units of service at \$20 a unit. That member decides that they would like to self-direct their services. The amount authorized is \$200 in the traditional service plan. A utilization adjustment factor of 80% is applied. The member's individual budget amount then becomes \$160 (\$200 X 80%). The 20% reduction (100% authorization minus 80% actual utilization for a service) is applied to allow for cost neutrality between the service under the traditional waiver plan and self-direction. If the average service utilization is only 80% of an authorized service under the traditional waiver, then a self-directed member is limited to that same 80% to preserve cost neutrality. The total monthly cost of all services (traditional and self-directed services) cannot exceed the established aggregate monthly cost of the traditional services authorized.

If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. Exceptions to policy may be granted to the requestor when the member has needs beyond the limits expressed in the Iowa Administrative Code. For fee-for-service enrollees this decision is made by the Director of DHS, based on an evaluation of the member's needs in relation to the State's necessity to remain within the waiver's parameters of cost neutrality. The process to request an exception is shared on the DHS website as well as with the member when they apply for waiver services. In addition, any member has the right to appeal any decision made by DHS and to request an appeal hearing by an administrative law judge. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

The MCOs operate an exception to policy process for their members. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to DHS. In addition, MCO members have the right to appeal any decision made by the MCO and may appeal to the DHS once the MCO appeals process has been exhausted as described in F-1.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS and MCO) will be informed of their budget amount during the development of the service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can request a review of the service plan.

As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. In addition, any member has the right to appeal any decision. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the case manager, integrated health care coordinator, or community-based case manager to inform the member of the budget amount allowed for services before the service plan is completed.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

- ☐ Modifications to the participant directed budget must be preceded by a change in the service plan.
- ☒ The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

For both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. This budget amount is the same amount whether the member utilizes only traditional waiver services, utilizes only self-directed services, or uses a combination of traditional and self-directed services. All services under the waiver add into the one budget and that budget maximum is determined by the member's level of care and not by the type of services accessed by the member.

Once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the service plan as long as it does not exceed the authorized budget amount. They must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Self-direction budgets are authorized monthly. Members, regardless of delivery system (i.e., FFS and MCO) can make adjustments at any time within the authorized amount if services are not meeting their needs, and the ISB via the FFS or MCO delivery system is available to provide assistance. The ISB also routinely monitors expenses. The FMS also monitors the budget and notifies the ISB and the member immediately if claims are inconsistent with the budgeted amount or if the budget is consistently underutilized.

When members chose self-direction they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

FEE FOR SERVICE:

Members are given an oral explanation of the appeals (State Fair Hearing) process during the application process by the Iowa Department of Human Services (DHS) income maintenance staff. The Department also gives members an oral explanation at the time of any contemplated adverse benefit determination. Depending on the adverse benefit determination, this could be provided by the income maintenance worker, case manager, integrated health care coordinator, community-based case manager, and/or medical provider performing the level of care determination. The member is also given written notice of the following at the time of application; and, at the time of any department adverse benefit determination. An adverse benefit determination affects a claim for assistance in which applicants are not provided the choice of home and community based services as an alternative to institutional care and members are denied services or providers of their choice, or whose services are denied, suspended, reduced or terminated.

An adverse benefit determination notice of determination that results in members' right to appeal includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, provisions for payment of legal fees by DHS; and how to obtain assistance, including the right to continue services while an appeal is pending.

The choice of HCBS vs. institutional services is discussed with the member at the time of the completion of the application by DHS income maintenance staff; and again at the time of the service plan development by the case manager, integrated health care coordinator, or community-based case manager.

All DHS application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the DHS website. The process for filing an appeal can be found on all Notices of Decision (NOD). Procedures regarding the appeal hearing can be found on the Notice of Hearing. As stated in Iowa Administrative Code, any person or group of persons may file an appeal with DHS concerning any decision, made. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the DHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing.

All notices are kept at all local DHS Offices or the case manager, integrated health care coordinator, or community-based case manager's file. The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

MANAGED CARE ORGANIZATIONS:

When an HCBS member is assigned to a specific MCO, the assigned MCO community based case manager explains the member's appeal rights through the Fair Hearing process during the initial intake process.

In accordance with 42 CFR 438, an adverse benefit determination means any of the following:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the

standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

In accordance with 42 CFR 438, an appeal means a review by an MCO of an adverse benefit determination that it has issued.

MCOs give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438. MCO enrollment materials must contain all information for appeals rights as delineated in 42 CFR 438.10, including: (A) the right to file an appeal; (B) requirements and timeframes for filing an appeal; (C) the availability of assistance in the filing process; (D) the right to request a State Fair Hearing after the MCO has made a determination of a member's internal MCO appeal which is adverse to the member. The fact that, if requested by the member, benefits that the MCO seeks to reduce or terminate will continue if the member files an appeal or requests a State fair hearing within the specified timeframe and that the member may be required to pay the cost of such services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member.

MCOs must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability. Upon determination of the appeal, the MCO must ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The MCO's appeal decision notice must describe the adverse benefit determinations taken, the reasons for the adverse benefit determination, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

MCOs must maintain an expedited appeals process when the standard time for appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. The MCO must also provide general and targeted education to members and providers regarding expedited appeals including when an expedited appeal is appropriate and procedures for providing written certification thereof.

The MCO's appeal process must conform to the following requirements:

- Allow members, or providers acting on the member's behalf, sixty (60) calendar days from the date of adverse benefit determination notice within which to file an appeal.
- In accordance with 42 CFR 438.402, ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
- The MCO must dispose of expedited appeals within 72 hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c).
- In accordance with 42 CFR 438.410, if the MCO denies the request for an expedited resolution of a member's appeal, the MCO must transfer the appeal to the standard thirty (30) calendar day timeframe and give the member written notice of the denial within two (2) calendar days of the expedited appeal request. The MCO must also make a reasonable attempt to give the member prompt oral notice.
- The MCO must acknowledge receipt of each standard appeal within three (3) business days.
- The MCO must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 CFR 438.408. If the timeframe is extended, for any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.
- In accordance with 42 CFR 438.408, written notice of appeal disposition must be provided with citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination in non-authorization and care review letters that advise members of the right to appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice. The written notice of the resolution must include the results of the resolution and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice must include the right to request a State fair hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The MCO shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal. This shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Contractor's adverse benefit determination.

Members enrolled in an MCO must exhaust the entity's internal grievance processes before pursuing a State Fair Hearing. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☐ No. This Appendix does not apply
- ☒ Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each MCO operates its own internal grievance and dispute resolution processes. In accordance to 42 CFR 438.408 (f), a managed care enrollee may request a State Fair Hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915 (b) waiver, Part IV, Section E. MCO members can appeal any adverse benefit determination within 60 calendar days. An adverse benefit determination is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

- (ii) reduction, suspension or termination of a previously authorized service;
- (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner;
- (v) failure of the MCO to act within the required timeframes; or
- (vi) the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

MCOs must ensure that oral requests seeking to appeal an adverse benefit determination are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution. MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408. Expedited appeals must be disposed within seventy-two (72) hours unless the timeframe is extended pursuant to 42 CFR § 438.408 and 410.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination." MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of adverse benefit determination, including information that the MCO grievance and appeals process is not a substitute for a Fair Hearing. MCOs must acknowledge receipt of a grievance within three (3) business days and must make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member's health condition requires. This timeframe may be extended up to fourteen (14) calendar days, pursuant to 42 C.F.R. § 438.408.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*

- ☐ No. This Appendix does not apply

- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

FEE FOR SERVICE:

IME is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS Quality Assurance and Technical Assistance Unit contract that is responsible for the handling of fee-for-service member complaints and grievances in regards to provision of services under this waiver.

MANAGED CARE ORGANIZATION:

IME Member Services MCO Member and MCO Liaison: Designated IME Member Services staff serves as a liaison for any MCO grievance/complaint that is reported to IME Policy staff by an MCO member or his/her advocate. IME Policy sends the pertinent details of the grievance/complaint to the MCO liaison. The IME MCO liaison communicates and coordinates with the MCO and member to grievance/complaint to resolution; and, the resolution is communicated to the IME Policy staff who received the original grievance/complaint. This process serves to support those MCO members who may be confused about the MCO grievance/complaint process to follow or members who have not been able to resolve their grievance/complaint with their MCOs.

Grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A grievance/complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

MCO Grievance/Complaint System:

The MCO must provide information about its grievance/complaint system to all providers and subcontractors at the time they enter into a contract. Further, the MCO is responsible for maintenance of grievance records in accordance with 42 CFR 438.416.

The MCO must provide information about its grievance/complaint system to all members and provide reasonable assistance in completing forms and taking procedural steps. This responsibility also includes; but is not limited to, auxiliary aids and services upon request (e.g. interpreter services and toll-free numbers that have TTY/TTD and interpreter capability).

The MCO member handbook must include information, consistent with 42 CFR 38.10.

The MCO must insure that individuals who make decisions on grievances have not been involved in any previous level of review or decision-making and is not a subordinate of such individual.

MCO Grievance/Complaint Process:

A member may submit an oral or written grievance at any time to the MCO. With written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. There is not a timeline for submission.

The MCO must acknowledge receipt of the grievance.

The MCO must process the grievance resolution within 30 days of the date that the grievance is received and issue a written notification to the member in accordance with 42 CFR 438.408.

The resolution may be extended by fourteen (14) days upon member request. If the member does not request an extension, the MCO must make reasonable efforts to give the member prompt oral notice of the delay; and within two (2) calendar days provide the member with a written notice of the basis for the decision to extend the

timeframe. If the member does not agree with the extension, he/she may file an additional grievance to the extension.

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member. A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report. The complaint may be submitted to an HCBS Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Assurance and Technical Assistance Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a member, they are informed by the HCBS Quality Assurance and Technical Assistance Unit Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO members must exhaust the entity's internal grievance and appeals processes before pursuing a State Fair Hearing. The policies and procedures regarding the MCO grievance and appeals system are outlined in the concurrent §1915(b) waiver, Part IV, Section E. MCO members can appeal any "action" within 60 days. An "action" is defined as the: (i) denial or limited authorization of a requested service, including the type or level of service; (ii) reduction, suspension or termination of a previously authorized service; (iii) denial, in whole or in part, of payment for a service; (iv) failure to provide services in a timely manner; or (v) failure of the MCO to act within the required timeframes set forth in 42 CFR 438.408(b). In accordance with 42 CFR 438.406, oral requests seeking an appeal are treated by the MCO as an appeal; however, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

MCO members have the right to request a State Fair Hearing if dissatisfied with the outcome of the MCO appeals process. MCOs notify members of this right through enrollment materials and notices of action. In accordance with 42 CFR 438.406, the MCO provides the member and their representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and their representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing. Upon determination of the appeal, the MCO must promptly notify the member and his/her representative of the appeal decision. The MCO's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, process for filing a Fair Hearing and other information set forth in 42 CFR 438.408(e).

MCOs must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues. Appeals must be resolved by the MCO within 30 calendar days of receipt; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs must resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Such expedited appeals must be resolved within 72 hours after the MCO receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408(c). Standard appeals must be resolved within 30 calendar days; this timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. Within 90 calendar days of the date of notice from the MCO on the appeal decision, the member may request a State Fair Hearing.

MCO members can also file grievances with their MCO; grievances are any written or verbal expression of dissatisfaction about any matter other than an "action," as defined above. Grievances may be filed either orally or in writing; receipt is acknowledged by the MCO within 3 business days and resolved within 30 calendar days or as expeditiously as the member's health condition requires. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c).

MCOs are required to track all grievances and appeals in their information systems; this includes data on clinical reviews, appeals, grievances and complaints and their outcomes. MCOs are responsible for reporting on grievances and appeals to DHS. This includes maintenance and reporting to the State the MCO member grievance and appeals logs which includes the current status of all grievances and appeals and processing timelines.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- ☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)
- If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver service providers, case managers, integrated health home care coordinators, and MCO CBCMs, regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to DHS upon request. Providers, case managers, integrated health home care coordinators, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by DHS. MCOs must require that all internal staff and network providers report, respond to, and document critical incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals.

Per Chapter 441 Iowa Administrative Code 77.25(1), "major incidents" are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or (7) involves a participant's location being unknown by provider staff who are assigned protective oversight. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME's Iowa Medicaid Portal Access (IMPA) System. Suspected abuse or neglect may be reported to the statewide abuse reporting hotline operated by DHS.

Child and dependent adult abuse is an inclusive definition that includes physical and sexual abuse, neglect and exploitation. Child abuse is defined in Iowa Code 232.68, and may include any of the following types of acts of willful or negligent acts or omissions:

- Any non-accidental physical injury.
- Any mental injury to a child's intellectual or psychological capacity.
- Commission of a sexual offense with or to a child.
- Failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing or other care necessary for the child's health and welfare.
- Presence of an illegal drug in a child's body as a direct act or omission of the person responsible for the care of a child or manufacturing of a dangerous substance in the presence of a child.

Dependent adult abuse is defined in Iowa Code 235B.2, and may include any of the following types of acts of willful or negligent acts or omissions:

- Physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- Commission of a sexual offense or sexual exploitation.
- Exploitation of a dependent adult.
- Deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care or other care necessary to maintain a dependent adult's life or health.

When a major incident occurs, provider staff must notify the member or the member's legal guardian within 24 hours of the incident and distribute a complete incident report form as follows:

- Forward a copy to the supervisor within 24 hours of the incident.
- Send a copy of the report to the member's case manager, health home coordinator, or community-based case manager (when applicable) and the BLTC within 24 hours of the incident.
- File a copy of the report in a centralized location and make a notation in the member's file.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the member's file.

As part of the quality assurance policies and procedures for HCBS Waivers, all incidents will be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a QA committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.

MCOs are also required to develop and implement a critical incident management system in accordance with DHS requirements, in addition to maintaining policies and procedures that address and respond to incidents, remediate the incidents to the individual level, report incidents to the appropriate entities per required timeframes, and track and analyze incidents.

MCOs must adhere to the State's quality improvement strategy described in each HCBS waiver and waiver-specific methods for discovery and remediation. MCOs must utilize system information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. All MCO staff and network providers are required to:

- Report critical incidents.
- Respond to critical incidents.
- Document critical incidents.
- Cooperate with any investigation conducted by the HCBS Quality Assurance and Technical Assistance Unit staff, MCO, or outside agency.
- Receive and provide training on critical incident policies and procedures.
- Be subject to corrective action as needed to ensure provider compliance with critical incident requirements.

Finally, MCOs must identify and track critical incidents, and review and analyze critical incidents, to identify and address quality of care and/or health and safety issues, including a regular review of the number and types of incidents and findings from investigations. This data should be used to develop strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation,

including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections is provided to applicants and members at the time of application and at the time of service plan development. During enrollment, and when any updates are made, DHS also provides to members a Medicaid Members Handbook, which contains information regarding filing a complaint or grievance. MCO written member enrollment materials also contain information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.

In addition, information can also be found on DHS and MCO websites. The DHS website contains a "Report Abuse and Fraud" section, which describes how to report dependent adult child abuse. The same information is also available in written format in the 99 local DHS offices, and members may also call the IME Member Services call center with any questions regarding filing a complaint or grievance.

Finally, the case manager, health home coordinator, or community-based case manager is responsible for assessing a member's risk factors annually during the reevaluation process, as well as during the quality assurance interview process and the annual IPES interview. DHS recognizes the need to provide training to members using on a more formal process. The state has developed training to ensure that case managers, health home coordinators, and community-based case managers provide this information to members at a minimum on a yearly basis.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reporting of suspected child or adult abuse to DHS Protective Services is mandatory for all IME HCBS staff, case managers, MCO CBCMs, health home care coordinators, and HCBS providers. DHS Protective Services (PS) receives all mandatory reports of child and dependent adult abuse. If an immediate threat of physical safety is believed to exist, PS makes every effort to examine that child or dependent adult within one hour of receipt and take any lawful action necessary. If the child or dependent adult is not in danger, PS makes every effort to examine the child or dependent adult within 24 hours. PS notifies the member's case manager, health home coordinator or community-based case manager when an investigation has been initiated to ensure they are aware of the alleged abuse, and to ensure that additional services can be added or that changes can be made to the member's plan of care if needed. PS provides an evaluation report within twenty days of receipt of the report, which includes necessary actions, and/or an assessment of services needed. The Central Registry of Abuse and County Attorney also receives PS reports. For both child and dependent adult abuse cases, the member and/or the family are notified of the results in writing by DHS as soon as the investigation has concluded. This applies to both individuals enrolled in fee-for-service or managed care.

If the incident is a situation that has caused, or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed, or is in the process of conducting, an investigation the HCBS specialist coordinates activities with PS to ensure the safety of the member is addressed. If PS is not investigating, and immediate jeopardy remains, the member's case manager, health home coordinator, or community-based case manager is notified immediately to coordinate services, and the HCBS Specialist initiates a review within two working days of receipt of the report. If it is determined that immediate jeopardy has been removed or not present, review by the HCBS Specialist is initiated within twenty working days of receipt of report. The HCBS Specialist prepares a report of findings within thirty days of the investigation being completed and presents it to the BLTC, the provider, and interested stakeholders (i.e., members, guardians, etc.). These timelines apply to both individuals enrolled in fee-for-service or managed care.

The BLTC meets biweekly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. DHS reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case manager, health home coordinator, community-based case manager, or HCBS Specialist. Requests for information are forwarded to the case manager, health home coordinator or community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the

Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

Information requests to the case manager, health home coordinator, community-based case manager, or HCBS Specialist for follow up are tracked by the HCBS Unit on a weekly basis until the situation has been resolved. DHS implemented a web-based critical incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the critical incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process. Incidents are reviewed by the HCBS Quality Oversight Unit within one business day of report and forwarded to the case manager, health home coordinator or community-based case manager as needed to coordinate any follow-up and communication with the member, provider, and/or family/legal guardian. Incidents that lead to targeted review will initiate investigation by the HCBS Quality Oversight Unit within one business day. Findings reports are submitted to the Quality Assurance Manager within 15 days of investigation completion. Once the finding report is approved by the Quality Assurance Manager, the findings report is sent to the provider and case manager, health home coordinator, community-based case manager, or HCBS Specialist.

MCOs are responsible for developing and implementing critical incident management systems in accordance with the DHS requirements. Specifically, MCOs must maintain policies and procedures, subject to DHS review and approval, that: (1) address and respond to incidents; (2) report incidents to the appropriate entities per required timeframes; and (3) track and analyze incidents. This information is utilized to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care. Training must be provided to all internal staff and network providers regarding the appropriate procedures for reporting, responding to, and documenting critical incidents. Network providers must provide training to direct care staff regarding the appropriate procedures for reporting, responding to, and documenting critical incidents.

Finally, MCOs must identify and track, review and analyze critical incidents to identify and address quality of care and/or health and safety issues. MCOs must also regularly review the number and types of incidents and findings from investigations, in order to identify trends, patterns, and areas for improvement. Based on these findings, the MCO must develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. Consistent with 441 Iowa Administrative Code 77.25 (3), the following process is followed when a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

- a. The staff member's supervisor.
- b. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to a guardian, if any, is always required.
- c. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization or for members not enrolled with a MCO, the department's bureau of long-term care either:

- a. By direct data entry into the Iowa Medicaid Provider Access System, or
- b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

- a. The name of the member involved.
- b. The date and time the incident occurred.
- c. A description of the incident.
- d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
- e. The action that the provider staff took to manage the incident.
- f. The resolution of or follow-up to the incident.
- g. The date the report is made and the handwritten or electronic signature of the person

making the report.

If the critical incident involves the report of child or dependent adult abuse, it is mandatory that this type of critical incident is reported to DHS Protective Services.

If the critical incident does not involve child or dependent adult abuse, it will be reviewed by the MCO. The MCO will notify the member and/or the family of the results upon conclusion of the investigation, on or within 30 days.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS has oversight for monitoring incidents that affect all waiver members. An HCBS Quality Assurance and Technical Assistance Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided.

If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the member, and if PS has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member has been removed from immediate jeopardy, the review is initiated within twenty working days of receipt of report. For other non-jeopardy incidents, a review is initiated within twenty days.

The HCBS Quality Assurance and Technical Assistance Unit meets biweekly to review data tracked in the critical incident database and to decide if policy changes or additional training are needed. Data is compiled and analyzed in attempt to prevent future incidents through identification of system and provider specific training needs, and individual service plan revisions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☐ The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

☒ The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding restraints is as follows and applies to all types of restraints that may be used by waiver providers. The policy described in this section applies regardless of delivery system (i.e., FFS or MCO), and MCOs are contractually obligated to adhere.

Restraints include, but are not limited to, personal, chemical, and mechanical methods used for the purpose of controlling the free movement of an individual's body. Chemical restraints are most commonly used to calm an individual down in moments of escalation. Other examples of restraints

include, but are not limited to, holding a person down with one's hands, tying an individual to a bed, using a straight jacket or demobilizing wrap. As a rights limitation, the restraint procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of restraints must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- Restraint, restriction, and behavioral intervention programs shall be time-limited (maximum one year) and shall be reviewed at least quarterly.
- Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restraints are used. All restraints must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restraint procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Physical and chemical restraints may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. These types of restraints must be considered on an individual basis after the interdisciplinary team reviews them, and entered into the written plan of care with specific time lines. If a member were placed in a closed room the time frame would need to be determined on an individual basis and spelled out in the service plan. The provider would need to document the use of this restraint in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, for example monitoring on a fifteen minute basis to assure the health and welfare of the member.

Restraint procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of restraints and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restraints and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. Staff must be trained and exhibit proficiency as described below before administering restraints. An employee's ability to implement a procedure must be documented in one of the following

ways:

- A program staff person may observe each employee in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Restraints and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, integrated health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- A Restraint and Behavioral Intervention Program that is a part of the written individual service plan developed by the member's case manager, integrated health home coordinator, or community-based case manager, and in the provider plan of care developed for the member.
- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components: (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior; (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors; (iii) description of the conditions that precede the behavior in question; (iv) description of what appears to reinforce and maintain the behavior; and (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restraints must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restraints are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of restraints would be detected via:

- interviews with the member, their family and staff and case manager, integrated health home coordinator, or community-based case manager;
- through review of critical incident reports by DHS and member's case manager, integrated health home coordinator, or community-based case manager on a daily basis;
- DHS and case manager, integrated health home coordinator, or community-based case manager review of written documentation authored by provider staff;
- through the annual review activities associated with the provider Self-Assessment process;
- and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restraint is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, integrated health home coordinator, or community-based case manager is responsible to monitor individual plans of care including the use of restraints and behavioral interventions.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of restraints and ensuring safeguards are in place is the member's case manager, integrated health home coordinator, or community based case manager. The use of restraints must be assessed as needed and identified in the individual member's service plan. The use of restraints would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, integrated health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed.

The State also contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restraints. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restraints are appropriately incorporated into the service plan, such that restraints are only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of restraints. For fee-for-service members these reports are entered into IMPA, triggering milestones in ISIS that alert case managers and integrated health home coordinators, and prompting the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restraints, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES

tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, at the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of restraints, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restraints would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- ☐ The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- ☒ The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

FFS and MCO

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention.

The DHS policy regarding restrictive interventions is as follows, and applies to all types of restrictions that may be used by waiver providers. A restrictive intervention is an action or procedure that limits a member's movement, access to other individuals, locations or activities, or restricts a member's rights. The use of any restrictive interventions as part of the waiver program is treated as rights limitations of the member receiving services. As a rights limitation, the restrictive interventions must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code 83.67(4)).

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the

review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

These safeguards are the same regardless of what restrictions are used. All restrictions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Restrictions may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

The case manager, health home coordinator, or community-based case manager has the responsibility to assess the need for the restrictive interventions, identify the specific restrictive intervention, explain why the intervention is being used, identify an intervention plan, monitor the use of the restrictive intervention, and assess and reassess need for continued use. The service plan authorizes the services to be delivered to the member and identifies how they are to be provided. Without the authorization, services cannot be provided to a member.

Providers are required to use the service plan as the basis for the development and implementation of the providers' treatment plan. The provider is responsible for developing a plan to meet the needs of the member and to train all staff on the implementation strategies of the treatment plan, such that the interventions are individualized and in accordance with the previously devised plan. Providers and the case manager, health home coordinator, or community-based case manager are responsible for documenting all behavioral interventions, including restrictive interventions, in the service plan as well as the member's response to the intervention. Providers and case manager, health home coordinator, or community-based case manager are also required to submit critical incident reports to the BLTC care, via the IMPA, any time a restrictive intervention is utilized.

Providers are required to maintain a system for the review, approval and implementation of ethical, safe, humane and efficient behavioral intervention procedures, that inform the member and his/her legal guardian of the behavioral intervention policy and procedures at the time of entry into a facility and as changes occur. Non-aversive methods of intervention must be designed and utilized as the option of first use, prior to design or implementation of any behavioral intervention containing aversive techniques.

Behavioral intervention procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a nonaversive program. Behavioral intervention procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. Corporal punishment and verbal or physical abuse are prohibited. Restrictions may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be

reinforced.

- A list of restrictions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Restrictions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (i) the supervisor's ability to implement the procedure has been documented by a program staff person; (ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an member's behaviors.

Restrictions and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter a member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member's service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements:

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the member's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the member and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the Behavioral Intervention Program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as, and includes, the following components:
 - (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
 - (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
 - (iii) description of the conditions that precede the behavior in question;
 - (iv) description of what appears to reinforce and maintain the behavior; and
 - (v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.

- Documentation of all prior programs used to eliminate a maladaptive target behavior.
- Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Restrictions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All restrictions are explained to the member and their legal representative and agreed upon ahead of time. Unauthorized use of restrictions would be detected via interviews with the member, their family and staff and case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints).

Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified restriction is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of restrictions and behavioral interventions.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

A restrictive intervention is an action or procedure that imposes a restriction of movement, that limits a participant's movement, access to other individuals, locations or activities, or restricts a participant's rights. 441-IAC 77.25(4) describes restrictive interventions as restraints, restrictions and behavioral intervention. Per the description of restrictive interventions noted in the application (G-2-b-i) above, Iowa will need to review its inclusion of restraint as a restrictive intervention.

The first line of responsibility for overseeing the use of restrictive interventions and ensuring safeguards are in place is the member's case manager, integrated health home care coordinator, or community based case manager. The use of restrictive interventions must be assessed as needed and identified in the individual member's service plan. The use of restrictions would also require the development and implementation of a restrictive intervention plan and the plan would be included in the participant's service plan. The member's case manager, integrated health home care coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with restrictions. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether restrictions are appropriately incorporated into the service plan, such that restrictions are only implemented as designated in the plan (who, what, when, where, why, and how). If

the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers, regardless if serving FFS or MCO members, are required to submit major incident reports. Categories within the incident report include inappropriate use of restrictions.

FFS

For FFS members, provider reports of restrictive interventions are entered into IMPA, which trigger milestones in ISIS for fee-for-service members. These triggers alert case managers and integrated health home care coordinators, and prompt the IME HCBS Incident Reporting Specialist to conduct a review of the restrictive intervention. If it is found that the restrictive intervention demands further investigation, the issue is passed to the HCBS Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of restrictions, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to the IME Program Integrity Unit for possible sanctions that may apply.

MCO

For MCO members, provider reports are entered into the designated MCO critical incident reporting system. In the MCO system and processes, MCO CBCMs are alerted along with the MCO Critical Incident Reporting Specialist to conduct a review of the restrictive intervention. Processes for targeted review, provider corrective actions and PI referral, if warranted, are followed as discussed in the FFS process.

IPES INTERVIEWS

The HCBS Quality Assurance Unit is also responsible for conducting IPES interviews for FFS members. The MCOs conduct the same IPES interviews for MCO members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the individual interviewed and service enrollment. IPES interviews are conducted either face-to-face or via telephone at the discretion of the waiver member. All waiver members have the right to decline an interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the HCBS Unit compiles all data related to incidents associated with the inappropriate use of restrictions, as well as data from periodic and targeted provider reviews. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

MCO Community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of restrictive interventions would be addressed with the provider of service and corrected as needed. In addition, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☐ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

☒ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHS policy regarding seclusion is as follows, and applies to all types of seclusions that may be used by waiver providers, regardless of delivery system (i.e., FFS or MCO) Examples of seclusion include but are not limited to locking an member in a room, locking an member out of an area of their residence, or limiting community time. All incidents of seclusion must be documented in the member's service record and reported to the IME as a critical incident. As a rights limitation, the seclusion procedures must be agreed to by the interdisciplinary team and identified in the member's plan of care (441 Iowa Administrative Code Chapter 83). All incidents of seclusion must be documented in a member's file and reported as a critical incident.

Per 441 Iowa Administrative Code Chapter 77.25(4), providers "shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures." All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

- a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
- b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
- d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
- e. Corporal punishment and verbal or physical abuse are prohibited."

The same standard is used for seclusion as a restrictive intervention. All seclusions must also be consistent with the Children's Health Act of 2000 and other applicable Federal laws. All members served under an HCBS waiver service shall be afforded the protections imposed by these requirements. Any provider contracting with DHS to provide waiver services must conduct its activities in accordance with these requirements. Seclusion procedures may be designed and implemented only for the benefit of the member and may never be used merely as punishment or for the convenience of the staff or as a substitute for a non-aversive program.

Seclusion may be allowed depending on the provider's agency policy to ensure that there is an accompanying behavioral intervention plan, documentation of each instance, and monitoring of its use. Seclusion can be considered on an individual basis after the interdisciplinary team reviews them, and are entered into the written plan of care with specific time lines. If a member were placed in a closed room, the time frame would need to be determined on an individual basis and spelled out in the service plan.

The provider would need to document the use of this seclusion in the member's service file each time it was utilized by staff. The provider would be required to have a written policy approved by DHS on the supervision and monitoring of members placed in a closed room, such as monitoring on a fifteen minute basis to assure the health and welfare of the member.

Seclusion procedures may only be used for reducing or eliminating maladaptive target behaviors that are identified in the member's Behavioral Intervention Program. For the purposes of decelerating maladaptive target behaviors a Behavioral Intervention Program includes at least the following components:

- A clear objective description of the maladaptive target behavior to be reduced or eliminated.
- A clear objective description of the incompatible or alternative appropriate response, which will be reinforced.
- A list of seclusions and behavioral interventions utilized to teach replacement behaviors that serve the same behavioral function identified through a functional analysis or review of the maladaptive target behaviors. Seclusions and behavioral interventions may only be utilized to teach replacement behaviors when non-aversive methods of positive support have been ineffective.
- A baseline measurement of the level of the target behavior before intervention.

Any provider employee who implements an aversive procedure must be able to carry out the procedure as it is written. A person's ability to implement a procedure must be documented in one of the following ways:

- A program staff person may observe each person in a role-play situation in order to document his or her ability to implement the procedure as written.
- Supervisory personnel from the provider may provide documentation of employees' ability to implement a procedure if the following conditions are met: (
 - i) the supervisor's ability to implement the procedure has been documented by a program staff person;
 - ii) the supervisor observes each employee in a role play situation and documents the employee's ability to implement the procedure; and
 - (iii) the provider maintains a list of those employees who have been observed and are considered capable of implementing the procedure. The list should specify the dates that an employee demonstrated competency and the name of staff that certified the employee.
- Implementation of a program to alter an individual's behaviors.

Seclusion and behavioral intervention procedures must be implemented by systematic program review. It must ensure that a member's right to be free from aversive, intrusive procedures is balanced against the member's interests in receiving services and treatment whenever a decision regarding the use of aversive procedures is made. Any decision to implement a program to alter an member's behavior must be made by the interdisciplinary team and the program must be described fully as a Behavioral Intervention Program incorporated into the member service plan and the case manager, health home coordinator, or community-based case manager's plan of care. In general, the Behavioral Intervention Program must meet the following minimum requirements.

- Show that previous attempts to modify the maladaptive target behavior using less restrictive procedures have not proven to be effective, or the situation is so serious that a restrictive procedure is immediately warranted.
- The proposed procedure is a reasonable response to the person's maladaptive target behavior.
- Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention.
- Use the least restrictive intervention possible.
- Ensure the health and safety of the individual and that abusive or demeaning intervention is expressly prohibited.
- Be evaluated and approved by the interdisciplinary team through quarterly reviews of specific data on the progress and effectiveness of the procedures.

Documentation regarding the behavior program must include:

- Approval by the member's interdisciplinary team, with the written consent of the member's parent if the member is under eighteen years of age, or the member's legal guardian if one has been appointed by the court.
- A written endorsement from a physician for any procedure that might affect the member's health.
- A functional analysis that is defined as and includes the following components:

- (i) clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;
 - (ii) clear description of the need to alter the behavior; an assessment of the meaning of the behavior, which includes the possibility that the behavior is an effort to communicate, the result of medical conditions or environmental causes; or the result of other factors;
 - (iii) description of the conditions that precede the behavior in question;
 - iv) description of what appears to reinforce and maintain the behavior; and
 - v) a clear and measurable procedure, which will be used to alter the behavior and develop the functional alternative behavior.
- Documentation that the member, the guardian, and interdisciplinary team are fully aware of and consent to the program in accordance with the interdisciplinary process.
 - Documentation of all prior programs used to eliminate a maladaptive target behavior.
 - Documentation of staff training.

Behavioral Intervention Programs shall be time limited and reviewed at least quarterly. Seclusions must be considered on an individual basis after they are reviewed by the interdisciplinary team and entered into the written plan of care with specific time lines. All seclusions are explained to the member and their legal representative and agreed upon ahead of time.

Unauthorized use of seclusion would be detected via interviews with the member, their family and staff and case manager, health home coordinator, or community-based case manager; through review of critical incident reports by DHS and member's case manager, health home coordinator, or community-based case manager on a daily basis; DHS and case manager, health home coordinator, or community-based case manager review of written documentation authored by provider staff; through the annual review activities associated with the provider Self-Assessment process; and by reports from any interested party (complaints). Reviews may include desk reviews where the department requests member's records to be reviewed or onsite where the department or department designee goes onsite to review documentation. One hundred percent of waiver providers are reviewed at least once every five years to ensure that the DHS policy for each type of agency identified seclusion is observed and member rights are safeguarded. If it is found that a waiver provider is not observing DHS policy or ensuring a member's rights, adverse action is taken by the IME, which may include sanction, termination, required corrective action, etc.

The member's case manager, health home coordinator, or community-based case manager, is responsible to monitor individual plans of care including the use of seclusion and behavioral interventions.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The first line of responsibility for overseeing the use of seclusion and ensuring safeguards are in place is the member's case manager, health home coordinator, or community based case manager. The use of seclusion must be assessed as needed and identified in the individual member's service plan. The use of seclusion would also require the development and implementation of a behavior plan and the plan would be included in the member's service plan. The case manager, health home coordinator, or community based case manager is responsible for monitoring the service plan to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of seclusion would be addressed with the provider of service and corrected as needed.

The State contracts with the HCBS Quality Assurance and Technical Assistance Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with seclusion. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether seclusion is appropriately incorporated into the service plan, such that seclusion is only implemented as designated in the plan (who, what, when, where, why, and how). If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more

serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate use of seclusion. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers, health home coordinators and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding the use of seclusion, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The HCBS Quality Assurance and Technical Assistance Unit is also responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

Finally, the Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of seclusion, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☐ No. This Appendix is not applicable (do not complete the remaining items)
- ☒ Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Per 441 Iowa Administrative Code 77.46(5), respite providers must meet the following requirements as a condition of providing respite care under the waiver: (1) training on provision of medication according to agency policy and procedure; and (2) the staff member shall not provide any direct service without the oversight of supervisory staff until training is completed.

The case manager, health home coordinator, or community-based case manager, and any provider responsible for medication administration must monitor the documentation of medication administration to ensure adherence to the service plan and provider policies and procedure. The provider agency frequently and routinely monitors as outlined in their policies and procedures, and quality improvement plans. Provider agencies are expected to review medication administration on a daily basis to ensure health and welfare of member as well as perform quality assurance on a timeframe identified by the agency (most often monthly). The case manager, health home coordinator, or community-based case manager also monitor during the annual service plan development. MCO community-based case managers monitor the

documentation of medication administration to ensure adherence to the service plan and provider policies and procedures.

Monitoring includes review of the service documentation to ensure that medications have been administered at the designated times and by designated individuals. Further monitoring occurs through the report of major incidents whenever a medication error results in physicians' treatment, mental health intervention, law enforcement intervention, death, or elopement. When a major incident has occurred, follow-up, investigation, and remediation occurs as identified in G.I.d. All medication errors resulting in a major incident report or discovered via complaint are fully investigated. If it is determined that a harmful practice has been detected, the provider agency completes a corrective action plan and may face sanctions depending on severity and negligence of the circumstance.

The Iowa Medicaid program has actively managed Medicaid pharmacy benefits through a Preferred Drug List (PDL) since 2005. A governor appointed medical assistance pharmaceutical and therapeutics (P&T) committee was established for the purpose of developing and providing ongoing review of the PDL. The prior authorization department of the IME MSU utilizes the PDL to review medication management. First line responsibility lies with the prescriber who is contacted by fax or telephone regarding a prescription. Pharmacists review patient profiles for proper diagnosis, dosage strength and length of therapy.

The DHS Member Services Unit has established procedures to monitor Medicaid members' prescribing physicians and pharmacies. Analysis has established risk thresholds for these factors to mitigate possible abuse, harmful drug reactions, and to improve the outcomes of medication regimes for Medicaid members. When it is identified that members exceed the established risk thresholds, the member is placed in lock-in. Lock-in establishes one prescribing physician and one filling pharmacy for each member. The Member Services Unit also conducts statistical analysis of the use of certain drugs and usage patterns. Identification of trends for prescriptions and usage patterns of high risk or addictive medications is presented to DHS on a monthly or quarterly basis.

Second-line monitoring is conducted concerning the use of behavior modifying medications through a variety of mechanisms. First, member education is designed to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence. Second, restriction programs, including policies, procedures, and criteria for establishing the need for the lock-in, may also be implemented. Finally, medication therapy management programs are developed to identify and target members who would most benefit, and include coordination between the participant, the pharmacist and the prescriber using various means of communication and education.

The Drug Utilization Review (DUR) Commission is a quality assurance body, which seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The commission reviews policy issues and provides suggestions on prospective DUR criteria, prior authorization guidelines, OTC coverage, and plan design issues. The DUR system provides for the evaluation of individual member profiles by a qualified professional group of physicians and pharmacists, with expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluations and intervention, and medical quality assurance. Members of this group also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug interactions, drug-disease contraindications, therapeutic duplications, therapeutic benefit issues, and cost-effective drug strengths and dosage forms. In addition, the IME MSU reviews Medicaid member records to ensure that the member had a diagnosis or rationale documented for each medication taken.

The Department of Inspections and Appeals (DIA) is responsible for Medicaid member's medication regimes for waiver members served in an RCF/ID. All medical regimes are included in the member's record. Medications administered by the facility are recorded on a medical record by the individual who administers medication. All RCF/IDs are licensed facilities and must meet all Department of Inspections Administrative Rules to obtain an annually renewable license. Medical records are reviewed during licensure renewal. Persons administering medication must be a licensed nurse or physician or have successfully completed a department approved medication aide course. If the provider stores, handles, prescribes, dispenses, or administers prescription or over the counter medications the provider is required to develop procedures for the storage, handling, prescribing, dispensing, or administration of medication. For controlled substances,

providers must maintain DIA procedures. If the provider has a physician on staff or under contract, the physician must review and document the provider's prescribed medication regime at least annually in accordance with current medical practice. Policies and procedures must be developed in written form by the provider for the dispensing, storage, and recording of all prescription and nonprescription medications administered, monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, including antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. Policies and procedures are reviewed by the HCBS Specialists for compliance with state and federal regulations. If deficiencies are found, the provider is required to submit a corrective action, and follow-up surveys may be conducted based on the severity of the deficiency.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Second line responsibility is utilized when issues are more complex. Occurrences of high dosage use for certain medications or prescribing drugs for an age group where the drug is not FDA indicated are sent to DHS-IME for review. In some cases edits have been placed in the computer system so the prescriber could not prescribe for age groups not indicated.

Lock-In: Trending and analysis has been conducted by the MSU and "lock-in" strategies have been implemented for members who have, historically, multiple prescribers and pharmacies. Identification of these members allows the Medicaid payment of only one prescribing physician and one pharmacy. This allows for increased monitoring of appropriate medication management and mitigates the risk associated with pharmacological abuses and negative contraindications.

Drug Utilization Review (DUR) Commission: The DUR is a second line monitoring process with oversight by DHS. The DUR system includes a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness and positive provider relations. Letters to providers generated as a result of the professional evaluation process identify concerns about medication regimens and specific patients. At least one Iowa licensed pharmacist is available to reply in writing to questions submitted by providers regarding provider correspondence, to communicate by telephone with providers as necessary and to coordinate face-to-face interventions as determined by the DUR.

The Department of Inspections and Appeals (DIA): This DIA is responsible for oversight of licensed facilities. DIA communicates all findings to DHS and any issues identified during the RCF/ID licensure process, or critical incidents as they arise. The DIA tracks information and provides training as necessary to improve quality. This information is also shared with DHS. Both the DIA and DHS follow-up with identified RCF/IDs to assure that action steps have been made to ensure potential harmful practices do not reoccur.

HCBS Quality Assurance Unit: DHS contracts with the Unit to oversee the appropriateness, provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support

and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.).

All waiver service providers are required to submit major incident reports. Categories within the incident report include medication errors. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service members that alert case managers and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit discovers that the provider is less than compliant in areas surrounding medication management, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate use of medication, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ☐ Not applicable. *(do not complete the remaining items)*
- ☒ Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite Service providers must have policies and procedures developed for dispensing, storage, and recording all prescription and nonprescription medication administered. 441 Iowa Administrative Code Chapters 77.30(3)(b)(2), 77.33(6) (b)(2), 77.34(5) (b)(2), 77.37(15) (b)(2), 77.39(14) (b)(2), and 77.46(5)(e) state:

“Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing. All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name. In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.”

Providers are required to have staff trained on medication administration and provide safe oversight of medication administration. The State does not require specific medication administration curriculum to be used. Providers are responsible to assure that staff has the skills needed to administer medications

safely. There are no uniform requirements in the Iowa Administrative Code for the provision of medication administration or for the self-administration of medications by Medicaid members.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure for the storage and provision of medication. This process requires a more uniform approach for the provider in the requirements for medication management. The Provider Self-Assessment review checklist used by the HCBS Specialist to review providers identifies the following minimum standards that the medication policy will identify:

- The provider's role in the management and/or administration of medications
- If staff administers medications, the policy will identify the: (1) training provided to staff prior to the administration of medications; (2) method of documenting the administration of medications; (3) storage of medications; (4) the assessment process used to determine the Medicaid member's role in the administration of medications.

The provider Self-Assessment process also requires providers to have discovery, remediation and improvement processes for medication administration. The information and results of these activities is available to DHS upon request. Currently the self-assessment process is not set forth in the Iowa Administrative Code.

Home Health agencies that provide waiver services must follow Medicare regulations for medication administration and dispensing. All medications must be stored in their original containers with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to Medicaid members and the public. Nonprescription medications shall be labeled with the Medicaid member's name. In the case of medications that are administered on an ongoing long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription. All providers of respite must develop policies that assure that personnel that administer medications have the appropriate skills and that there is oversight by medical personnel.

Provider non-medical waiver staff that administers medications must have oversight of a licensed nurse. If the medication requires, the staff is required to complete a medication management course through a community college.

The requirements for non-medical waiver providers must have in order to administer medications to Medicaid members who cannot self-administer is that the provider must have a written policy in place on what the requirements are for their staff to do this and how. If the medications are psychiatric medications the person would have to have successfully completed a medication aide class. Oversight for a staff member who administers medications that require oversight such as in the case of psychiatric medications would need to follow the requirements as spelled out through the Board of Nursing such as having oversight by a registered nurse. The HCBS Specialists through IME would oversee this policy upon regular reviews of the provider.

State oversight responsibility is described in Appendix H for the monitoring methods that include identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.

iii. Medication Error Reporting. *Select one of the following:*

- ☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

Providers are required to complete incident reports for all occurrences meeting the criteria for major and minor incidents and make the incident reports and related documentation available to DHS upon request. Major incidents for members must be reported to the BLTC via IMPA. Providers must ensure cooperation in providing pertinent information regarding incidents as requested by DHS.

As part of the major incident reporting process described in Appendix G-1, DHS will review and follow-

up on all medication errors that lead to a member hospitalization or death. This can include the wrong dosage, the wrong medication delivered, medication delivered at the wrong time, Medicaid delivery not documented, unauthorized administration of medication, or missed dosage. Providers are required to submit all medication errors, whether major or minor, to the member's case manager, health home coordinator, or community-based case manager when they occur. The case manager, health home coordinator, or community-based case manager monitors the errors and makes changes to the member's service plan as needed to assure the health and safety of the member.

The Provider Self-Assessment quality improvement process requires providers to have a policy and procedure regarding medication administration and medication management. The Provider Self-Assessment process also requires that providers have discovery, remediation, and improvement processes for medication administration and medication errors. Specifically, providers are required to have ongoing review of medication management and administration to ensure that medications are managed and administered appropriately. Providers are also required to track and trend all medication errors to assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists. This will include random sampling of providers, incident specific review (complaint and IR follow up) and on-site provider review held every five years. DHS is in the process of promulgating rules to establish the Provider Self-Assessment quality improvement process in the Administrative Code.

Other professionals or family members may report medication error incidents at any time as a complaint. Suspected abuse is reported to the reporting hotline operated by the Department of Human Services.

(b) Specify the types of medication errors that providers are required to *record*:

Providers must track and trend all major and minor incident reports. Per Chapter 441 Iowa Administrative Code 77.25(1), "major incidents" are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or (7) involves a participant's location being unknown by provider staff who are assigned protective oversight. Service providers, provider staff, DHS TCM, MCO CBCM, health home coordinators, and community-based case managers are required to submit incident reports as they are witnessed or discovered. All major incidents must be reported within 48 hours of witnessing or discovering an incident has occurred, using the IME's Iowa Medicaid Portal Access (IMPA) System. Suspected abuse may be reported to the statewide abuse reporting hotline operated by DHS.

Per Chapter 441 Iowa Administrative Code 77.25(1), "minor incidents" are defined as an occurrence involving a participant during service provision that is not a major incident and that: (1) results in the application of basic first aid; (2) results in bruising; (3) results in seizure activity; (4) results in injury to self, to others, or to property; or (5) constitutes a prescription medication error. Providers are not required to report minor incidents to the BLTC, and reports may be reported internally within a provider's system, in any format designated by the provider (i.e., phone, fax, email, web based reporting, or paper submission). When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report must be maintained in a centralized file with a notation in the participant's file.

Providers are required to record all medication errors, both major and minor, that occur. Providers are required to track and trend all medication errors and assure all medication errors are reviewed and improvements made based on review of the medication error data. The information and results of these activities is made available to DHS upon request and will be reviewed as part of the ongoing Self-Assessment process conducted by the HCBS Specialists.

(c) Specify the types of medication errors that providers must *report* to the State:

Only major incidents of medication errors that affect the health and safety of the member, as defined by the major incident criteria, are required to be reported to the State. All medication errors, both major and minor, are required to be reported to the member's guardian, case manager, health home coordinator, or community-based case manager.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The BLTC is responsible for the oversight of waiver providers in the administration of medications to waiver members. Oversight monitoring is completed through IMPA, the provider Self-Assessment process and monitoring of the member by the member's case manager, health home coordinator, or community-based case manager.

With respect to MCO members, community based case managers are responsible for monitoring service plans to assure that supports and services in the service plan are being implemented as identified in the service plan. Any issues with the use of medication would be addressed with the provider of service and corrected as needed. In addition, MCOs must maintain documentation of the member's medication management done by the MCOs clinical staff; monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (a) identifying medication utilization that deviates from current clinical practice guidelines; (b) identifying members whose utilization of controlled substances warrants intervention; (c) providing education, support and technical assistance to providers; and (d) monitor the prescribing patterns of psychotropic medication to children, including children in foster care. Finally, MCOs must identify and track critical incidents, regularly review the number and types of incidents and findings from investigations, and develop and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members. MCOs are required to follow the process outlined at 441 Iowa Administrative Code 77.25 (3) for reporting major incidents. The State maintains ultimate oversight through the mechanisms identified in the submitted amendment (i.e., HCBS Quality Assurance and Technical Assistance Unit, critical incident review, etc.). All of these processes have been described in detail in this Appendix.

All medication errors are considered either major or minor incidents, as noted in Subsection "iii.b" above. These major incidents are reported to the department and follow the incident reporting follow up protocol of the department.

DHS contracts with the HCBS Quality Assurance Unit to oversee the appropriateness of provider policies and procedures, and service plan components associated with medication management. The Unit conducts periodic reviews of 100% of enrolled waiver service providers to ensure that policies and procedures are consistent with State and federal rule, regulations, and best practices. Further, the Unit examines member files, and conducts targeted reviews based on complaints, to ascertain whether medications are appropriately incorporated into the service plan. If the Unit discovers that the provider is less than compliant, the provider is required to complete a corrective action plan (CAP) and implement the CAP to 100% compliance. If it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

All waiver service providers are required to submit major incident reports. Categories within the incident report include inappropriate medication administration. These reports are entered into IMPA, trigger milestones in ISIS for fee-for-service participants that alert case managerx and health home coordinators, and prompt the HCBS Incident Reporting Specialist to conduct a review of the incident. If it is found that the incident demands further investigation, the issue is passed to the Unit for a targeted review. If the Unit

discovers that the provider is less than compliant in areas surrounding medication administration, the provider is required to complete a CAP and implement the CAP to 100% compliance. Again, if it is found that the circumstances are more serious, recommendations are made to PS and possible sanctions (suspension, probation, termination, etc.) may apply.

The Unit compiles all data related to incidents reported in IMPA associated with the inappropriate medication administration, as well as data from periodic and targeted provider reviews conducted by the Unit. Data is analyzed to identify trends and patterns and reported on a monthly and quarterly basis to DHS. Trends are used, along with those established in the monthly State QA Committee, to guide the dissemination of Informational Letters and revisions to State Administrative Rules.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-a1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated.

Numerator = # of critical incidents that received follow-up as required;

Denominator = # of critical incidents requiring follow-up escalation

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Data collected in the FFS and MCO CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

HW-a2: The IME will measure CIs that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

FFS and MCO CIR databases

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-b1: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days; Denominator = # of critical incidents that resulted in a targeted review.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

FFS/HCBS Unit and MCO data obtained from CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-c1: The IME will measure the total # and % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed that identified having policies for restrictive measures.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

**HW-d1: The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan;
Denominator = # of provider Quality Assurance Reviews completed.**

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

All QA reviews that don't result in a corrective action. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: contracted entity and MCO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed. The QIS developed by Iowa stratifies all 1915(c) waivers:

IA.0213, HCBS AIDS/HIV
 IA.0242, HCBS Intellectual Disability
 IA.0299, HCBS Brain Injury
 IA.0345, HCBS Physical Disability
 IA.0819, HCBS Children's Mental Health
 IA.4111, HCBS Health and Disability
 IA.4155, HCBS Elderly

DHS also provides §1915(i) services and strives to maintain consistency in QIS between these and the State's §1915(c) waivers.

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff.

Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

A comprehensive system of information and referrals shall also be developed such that all individuals are

allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: Contracted Entity (Including MCOs)	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The IME has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the IME policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to report results to agencies, waiver providers, participants, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS Quality Assurance Unit (QAU) completes review of HCBS enrolled providers on a three-five year cycle. During the onsite review HCBS ensures personnel are trained in:

- Abuse reporting
- Incident reporting
- Have current mandatory reporter training
- Individual member support needs
- Rights restrictions
- Provision of member medication

In addition HCBS QAU reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation any incident identified in narrative which falls under the Incident description in 77.25(3), is required to have an incident report filed. The agencies tracking and trending of incident reports is also reviewed during the onsite review. Any areas the agency may be out of compliance in results in the requirement of a corrective action plan. HCBS gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The IME Program Integrity (PI) unit conducts audits on all Medicaid Provider types including HCBS providers. Any suspected fraud is referred to the Department of Inspection and Appeals Medicaid Fraud and Control Unit (MFCU). The PI Unit vendor is contractually required to review a minimum of 60 cases in each quarter across all provider types. Reviewed cases include providers who are outliers on multiple parameters of cost, utilization, quality of care, and/or other metrics. Reviews are also based on referrals and complaints received. Reviews include review of claims data and service documentation to detect such aberrancies as up-coding, unbundling, and billing for services not rendered. This monitoring may involve desk reviews or provider on-site reviews. During a desk review the provider is required to submit records for review. The PI vendor must initiate appropriate action to recover improper payments on the basis of its reviews. They must work with the Core MMIS contractor to accomplish required actions on providers, including requests to recover payment through the use of credit and adjustment procedures.

The PI vendor must report findings from all reviews to DHS, including monthly and quarterly written reports detailing information on provider review activity, findings and recoveries. Requests for provider records by the PI unit include Form 470-4479, Documentation Checklist, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided. Reviews are conducted in accordance with 441 Iowa Administrative Code 79.4 (<https://www.legis.iowa.gov/docs/ACO/chapter/441.79.pdf>).

Since transitioning to a combined 1915(b)/1915(c) model on 4/1/2016, the vast majority of HCBS claims are paid through MCOs. The IME Program Integrity unit only reviews claims submitted through the Fee-For-Service (FFS) system for members who are not enrolled in an MCO. There are a relatively small number of HCBS claims in the FFS universe, and as such statistical sampling is unnecessary. It is more efficient and productive for the PI Unit to use more targeted strategies to identify providers for review, such as using data analysis and algorithms to identify billing aberrancies, as well as referrals and complaints that come from various sources. The PI vendor may conduct on-site reviews, but there is no requirement for a set percentage of reviews to be conducted on-site.

Should the State require a provider to perform a self-review, the prescribed methodology for review is determined on a case-by-case basis, and is generally determined based on the nature and scope of the issue identified. In previous years, all HCBS claims were paid through the FFS system; currently the vast majority of HCBS claims are paid by MCOs. The state compares the results of the MCO program integrity efforts to the results achieved in past years. However, MCO operations tend to rely more on prior authorization of services and pre-payment claims editing to control costs, and as such this type of comparison will not be straightforward and may not provide useful information.

When the PI vendor identifies an overpayment for FFS claims, a Preliminary Report of Tentative Overpayment (PROTO) letter is sent to the provider. The PROTO letter gives the provider an opportunity to ask for a re-evaluation and they may submit additional documentation at that time. After the re-evaluation is complete, the provider is sent a Findings and Order for Repayment (FOR) letter to notify them of any resulting overpayment. Both the PROTO letter and the FOR letter are reviewed and signed off by state PI staff prior to mailing. The FOR letter also includes appeal rights to inform the provider that they may appeal through the State Fair Hearing process. When overpayments are recovered, claims adjustments are performed which automatically results in the FFP being returned to CMS.

The OHCDs Medicaid audit is subject to the same standards and processes as outlined for FFS. The state's contracted MCOs are also responsible for safeguarding against, and investigating reports of, suspected fraud and abuse. MCOs are required to fully cooperate with the DHS PI Unit by providing data and ongoing communication and collaboration. Per 42 CFR 438.608 and 42 CFR Part 455, MCOs must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The PI Plan must be updated annually and submitted to DHS for review and approval. The MCOs are also required to make referral to IME and the MFCU for any suspected fraudulent activity by a provider. On a monthly basis, the MCO must submit an activity report to DHS, which outlines the MCO's PI-related activities and findings, progress in meeting goals and

objectives, and recoupment totals. Each MCO is also required to meet in person with the IME PI Unit, the IME Managed Care Oversight Bureau, and the MFCU on at least a quarterly basis to coordinate on open cases and review the MCO's program integrity efforts. Iowa's MCOs continuously conduct reviews/audits on providers in their networks. The degree to which these include HCBS providers varies over time depending on tips received and leads from data analytics.

As part of the 2017 EQR process, a focused study is being conducted regarding Person Centered Care Planning processes of the MCOs. The EQR vendor will be requesting documentation of person centered care planning (including whether or not services are being provided on an ongoing basis in the amount authorized in the service plan) for a sample of MCO members to verify that MCOs are providing services as authorized by the interdisciplinary team. Iowa will use the results of this focused study as a baseline to develop an ongoing review process to ensure MCOs are complying with the guidelines Iowa has provided for statistically significant samples, as well ensure that services are being provided according to the IDT authorized plan of care.

The state trends data from the MCO program integrity monthly reports to identify trends in number of tips received, number of audits/investigations opened and closed number of referrals to MFCU, number and amount of overpayments recovered. The State has not yet performed any root cause analysis on results of MCO reviews. Because the MCOs have been operational in Iowa for only a relatively short time and PI investigations can be lengthy, there is not yet enough data available for this type of analysis.

MCOs must also coordinate all PI efforts with IME and Iowa's MFCU. MCOs must have in place a method to verify whether services reimbursed were actually furnished to members as billed by providers, and must comply with 42 CFR Part 455 by suspending payments to a provider after DHS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual/entity unless otherwise directed by DHS or law enforcement. MCOs shall comply with all requirements for provider disenrollment and termination as required by 42 CFR §455.

The Auditor of the State has the responsibility to conduct periodic independent audit of the waiver under the provisions of the Single Audit Act. All HCBS cost reports will be subject to desk review audit and, if necessary, a field audit. However, the Waiver does not require the providers to secure an independent audit of their financial statements.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-a1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Program Integrity reviews claims and provider documentation for providers already under review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Annually a sample of claims from the 2 most utilized codes in the first year. Remaining codes are reviewed in following years. Documentation is reviewed to determine appropriate units.
	<input checked="" type="checkbox"/> Other Specify: quarterly across all waivers, annually for this waiver	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: quarterly across all waivers, annually for this waiver.

Performance Measure:

FA-a2: The IME will determine the number of clean claims that are paid by the managed care organizations within the time frames specified in the contract. Numerator = # of clean claims that are paid by the managed care organization within the time frames specified in the contract; Denominator = # of Managed Care provider claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Adjudicated claims summary, claims aging summary, and claims lag report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCOs	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-b1: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The DW Unit query pulls paid claims data for all seven of the HCBS waivers.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

FA-b2: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: contracted entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The following are reimbursed by fee schedules: (1) assisted living; (2) chore services; (3) personal emergency response or portable locator system; (4) nutritional counseling; (5) homemaker; (6) adult day health; (7) home delivered meals; (8) mental health outreach; (9) assistive devices; (10) senior companion; (11) respite (unless detailed otherwise below); and home and vehicle modification.

-Home Health Aide, Nursing Services, and Respite provided by home health agencies are based on a Medicare Low Utilization Payment Adjustment (LUPA) rates with state geographic wage adjustments less a budget-neutrality factor maintain Medical Assistance expenditures within the amounts appropriated by the Iowa General Assembly.

- Consumer directed attendant care services are reimbursed based on the agreement of the member and the provider.

- case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision.

- The transportation county rate is set based on the usual and customary transportation rate in the community (including rural and urban).

For services that the member self-directs through the Consumer Choices Option (i.e., self-directed personal attendant care, individualized directed goods and services, and self-directed community support and employment), the member negotiates a rate with the entity providing services, goods, and supports. The Financial Management Service and the Individualized Service Budget supports of CCO are reimbursed by a fee schedule that sets an upper limit for those services.

441 Iowa Administrative Code 79.1 sets forth the principles governing reimbursement of providers of medical and health services. Specifically, "[t]he basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member. Reimbursement types are described at 441 Iowa Administrative Code 79.1(1):

- c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time,

training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>. All provider rates are part of Iowa Administrative Code and are subject to public comment any time there is change. Rate determination methods are set forth in Iowa Administrative Code and subject to the State's Administrative Procedures Act, which requires a minimum twenty-day public comment period. A public hearing by the state agency to take comments is not required unless at least twenty-five persons demand a hearing, though Agency's often schedule a public hearing regardless of the number of comments received. The state agency may revise a rule in response to comments received but is not required to do so. This information is on the website as well as distributed to stakeholders when there is a change. Legislators consider constituent input and volume regarding the sufficiency of the rates balanced with budgetary allowances.

MCO capitation rate development methodologies are described in the §1915(b) waiver and associated materials. To estimate the fee-for-service population in Waiver Year 4, the State assumed that the same number of unique individuals would receive services for the waiver year, although the payment basis will be blended between fee-for-service and managed care based on the waiver effective date and managed care implementation date. As such, the average cost per unit is illustrated as a combination of that assumed previously for the fee-for-service population blended with the applicable portion of the year at the assumed managed care unit cost rates. The cost per unit for services delivered under managed care were developed as the fee-for-service cost per unit amounts grossed up to reflect total capitation payment reimbursement representing the average LTSS blended capitation rate for the rate cells. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State. Non-contract providers would be responsible for submitting claims to the MCO. The MCO would then reimburse the provider at a rate consistent with the MCO's contract with the State.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For fee-for-service members, providers shall submit claims on a monthly basis for waiver services provided to each member served by the provider agency. Providers may submit manual or electronic claim forms. Electronic claims must utilize a HIPAA compliant software, PC-ACE Pro 32, and shall be processed by the IME Provider Services Unit. Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.

Providers shall submit a claim form that accurately reflects the following: (1) the provider's approved NPI provider number; (2) the appropriate waiver procedure code(s) that correspond to the waiver services authorized in the ISIS service plan; and (3) the appropriate waiver service unit(s) and fee that corresponds to the ISIS service plan.

The IME issues provider payments weekly on each Monday of the month. The MMIS system edits insure that payment will not be made for services that are not included in an approved ISIS service plan. Any change to ISIS data generates a new authorization milestones for the case manager or health home care coordinator. The ISIS process culminates in a final ISIS milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

For MCO members, providers bill the managed care entity with whom a member is enrolled in accordance with the terms of the provider's contract with the MCO. Providers may not bill Medicaid directly for services provided to MCO members.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- ☒ No. State or local government agencies do not certify expenditures for waiver services.
- ☒ Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- ☐ Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS system edits to make sure that claim payments are made only when a member is eligible for waiver payments and when the services are included in the service plan. A member is eligible for a Medicaid Waiver payment on the date of service as verified in ISIS. The billing validation method includes the date the service was provided, time of service provision, and name of actual member providing the service. Several entities monitor the validity of claim payments: (1) case manager, or health home coordinator ensures that the services were provided by reviewing paid claims information made available to them for each of their members through ISIS; (2) the Iowa Department of Human Services Bureau of Purchased Services performs financial audits of providers to ensure that the services were provided; (3) the IME Program Integrity Unit performs a variety of reviews by either random sample or outlier algorithms.

The MMIS system includes system edits to ensure that prior to issuing a capitation payment to an MCO the member is eligible for the waiver program and is enrolled with the MCO. MCOs must implement system edits to ensure that claim payments are made only when the member is eligible for waiver payments on the date of service. The MCOs are required to develop and maintain an electronic community-based case management system that captures and tracks service delivery against authorized services and providers. The State monitors MCO compliance and system capability through pre-implementation readiness reviews and ongoing monitoring such as a review of sampled payments to ensure that services were provided and were included in the member's approved plan of care. The MCOs are also responsible for program integrity functions with DHS review and oversight.

When inappropriate billings are discovered (i.e.: overpayments determined) the provider is notified in writing of the overpayment determination. The provider either submits a refund check to the IME or the overpayment is set as a credit balance within the MMIS. Future claim payments are then used to reduce and eliminate the credit balance.

Meanwhile, the overpayments are recorded and reported to the state data warehouse using an end-of-month A/R reporting process. Any overpayments determined during a particular month are reported for that month. Any recoveries of these overpayments are similarly recorded and reported to the state data warehouse using the same end-of-month A/R process and for the month in which the recoveries were made. The dates on which the respective overpayments occurred and the recoveries made are part of this month-end A/R reporting. Bureau of Fiscal Management staff then extracts this reporting from the data warehouse to construct the CMS-64 report, the official accounting report submitted by the Department to CMS (the state's claiming mechanism for FFP). The CMS-64 report shows CMS what Iowa's net expenditures are for the quarter and is used to determine a final claim of federal funds. The federal-dollar share of any overpayments not recovered within 12 months of the payment itself must be returned to CMS and this is accomplished through the CMS-64 report as well.

Prevention of member coercion:

The case managers, IHH care coordinators, and MCO CCBCMs are responsible for conducting the interdisciplinary team for each member and ensuring the unencumbered right of the member to choose the provider for each service that will meet the member's needs.

The HCBS Unit completes the Iowa Personal Experience Survey to a random sample of members. A specific survey question relates to the members' ability to choose their providers. Any indication coercion will result in followup action by the HCBS staff.

The IME HCBS Unit observes a random sample of interdisciplinary team (IDT) meetings conducted by MCO Community Based Managers. This allows the HCBS Unit to note any member coercion in choice of providers. HCBS staff then requests the final service plan to ensure that the final plan does include the services, units and providers chosen by the member. Any changes and omissions require followup by the HCBS staff for resolution by the MCO.

As part of the 2017 EQR process, a focused study was conducted regarding Person Centered Care Planning processes of the MCOs. The EQR vendor conducted onsite visits to review MCO documentation of person centered care planning (including freedom of choice) for a sample of MCO members to verify that MCOs are maintaining records of such processes. The results of this study will be provided to the IME in Spring 2018. MCO account managers will then work with the MCOs to ensure that choice is documented as part of the overall process.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments – MMIS** (*select one*):

- ☐ Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- ☐ Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Payments for waiver services for fee-for-service members are made by DHS through the MMIS. Capitation payments to MCOs are made by the MMIS. The MMIS has member eligibility and MCO assignment information. When a member is enrolled in an MCO, this is reflected on his/her eligibility file and monthly payment flows from the MMIS to the MCO via an 837 transaction. A monthly payment to the MCO on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☒ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For fee-for-service members, for the self-direction option of the waivers, payments will be made to a financial management service, which will be designated by the state as an organized healthcare delivery system to make payments to the entities providing support and goods for members that self-direct. The financial management service must meet provider qualifications established by the state and pass a readiness review approved by the state and be enrolled as a Medicaid provider with the state. The state will also oversee the operations of the financial management service by providing periodical audits. Providers are informed about the process for billing Medicaid directly through annual provider training, IME informational bulletins, and the IME provider manual.

The fiscal agent mails to entities providing supports and goods for members that self-direct information how they can bill Medicaid directly if they choose. IME exercises oversight of the fiscal agent through both the ISIS system and through our "Core" unit. The Core unit performs a myriad of functions for the Iowa Medicaid Enterprise including, but not limited to, processing and paying claims, handling mail, and reporting. This unit also maintains and updates the automated eligibility reporting system known as ELVS. IME has regularly scheduled meetings with Core that has thresholds of measurements they are required to meet to assure quality.

- ☒ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

N/A

Appendix I: Financial Accountability**I-3: Payment (3 of 7)**

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ☒ **No. The State does not make supplemental or enhanced payments for waiver services.**
☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☐ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
☒ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

State of Iowa counties can own case management agencies, home delivered meal agencies, hospitals, regional transit agencies, and supported community living agencies which would therefore cause those counties to receive Medicaid payments as authorized in ISIS for those services.

Case management agency: can provide case management services.

Home delivered meal agency: can provide home delivered meals.

Hospitals: can provide respite, transportation, nutritional counseling.

Regional transit agencies: can provide transportation.

Supported community living agencies: can provide consumer directed attendant care.

Appendix I: Financial Accountability**I-3: Payment (5 of 7)**

- e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report.

Select one:

- ☒ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☐ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☒ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

For fee-for-service members, providers receive and retain 100% of the amount claimed to CMS for waiver services.

The payment to capitated MCOs is reduced by a performance withhold amount as outlined in the contracts between DHS and the MCOs. The MCOs are eligible to receive some or all of the withheld funds based on the MCO's performance in the areas outlined in the contract between DHS and the MCOs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- ☐ Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- ☐ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☒ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Enrolled Medicaid providers can choose to subcontract to non-enrolled providers for the provision of Home and Vehicle Modifications and Assistive Devices. The authorization for the service and the Medicaid payment for the authorized service is made to the enrolled Medicaid provider that would then forward payment to the subcontractor in accordance with their contract. Any subcontractor who is qualified to enroll with Iowa Medicaid is encouraged to do so. No provider is denied Medicaid enrollment for those services that they are qualified to provide. Waiver providers are not required to contract with an OHCDS in order to furnish services to members.

When the case manager, health home coordinator or community-based case manager has assessed the need for any waiver service, the member is offered the full choice of available providers. The member has the right to choose from the available providers; the list of providers is available through the case manager, health home coordinator or community-based case manager, and is also available through the IME and MCO websites. In accordance with the Iowa Administrative Code, all subcontractors must meet the same criteria guidelines as enrolled providers and the contracting enrolled provider must confirm that all criteria is met.

The Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C-3. Iowa Medicaid Enterprise (the state Medicaid agency) executes a provider agreement with the OHCDS providers and MCOs contract with an IME enrolled Financial Management Services solution. The Financial Management Services provided by the OHCDS is voluntary and an alternative billing and access is provided to both waiver members and providers. Members have free choice of providers both within the OHCDS and external to these providers. Providers may use the alternative certification and billing process developed by the Iowa Medicaid Enterprise. Members are given this information during their service plan development. Providers are given this information by the OHCDS.

The Designated OHCDS reviews and certifies that established provider qualifications have been met for each individual or vendor receiving Medicaid reimbursement. Annually each provider will be rectified as a qualified provider. Employer/employee agreements and timesheets document the services provided if waiver members elect to hire and manage their own workers. The purchase of goods and services is documented through receipts and/or invoices. For each purchase for fee-for-service members, Medicaid funding from the MMIS to the provider of the service is accurately and appropriately tracked through the use of Iowa's ISIS system.

Financial oversight and monitoring of the OHCDS is administered by the Iowa Medicaid Enterprise through an initial readiness review to determine capacity to perform the waiver services and throughout the year using a reporting system, random case file studies and the regular Medicaid audit process. MCOs are contractually required to develop a system to track all OHCDS Financial Management Services, which is subject to DHS review and approval. Further, the MCOs maintain financial oversight and monitoring with ongoing review and authority retained by DHS.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

- ☐ The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☒ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ This waiver is a part of a concurrent ☐1115/☐1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ☐1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☒ Appropriation of State Tax Revenues to the State Medicaid agency
- ☐ Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
☐ **Provider-related donations**
☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. **Services Furnished in Residential Settings.** *Select one:*

☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As specified in Iowa Administrative Code, Iowa does not reimburse for room and board costs, except as noted for providers of out of home respite services. The provider manuals contain instructions for providers to follow when

providing financial information to determine rates. It states that room and board cannot be included in the cost of providing services. Most respite payments are based upon fee schedules detailed in the Iowa Administrative Code. That fee schedule has no allowance for room and board charges.

Respite provided by a home health agency is based upon the LUPA rate as detailed in Appendix I-2a. Assisted Living facilities are authorized to provide the following services: home delivered meals, consumer-directed attendant care, personal emergency response, and assisted living service. The fees for these services are limited by fee schedules, which have no allowance for room and board charges. In addition, the fee charged must be substantiated by the costs to provide each specific authorized service, and not by the costs to perform all functions of the facility. Upon request from the department or designated review staff, each facility must be able to provide service cost information.

The exclusion of room and board from reimbursement is ensured by the Provider Cost Audit Unit. When providers submit cost report documentation and rate setting changes, the Provider Cost Audit Unit accounts for all line items and requests justification for all allocated costs (administrative and other). If it is determined that a provider has attempted to include room and board expenses in cost audits or rate setting documentation, the provider is instructed to make the adjustment and further investigation is conducted to determine if previous reimbursement needs to be recouped by the Iowa Medicaid Enterprise.

All providers of waiver services are subject to a billing audit completed by the Department of Human Services Bureau of Purchased services.

Any payment from an MCO to residential settings is made explicitly for the provision of services as defined by this waiver and excludes room and board. As part of the ongoing monitoring process of MCOs, the State will ensure that payments to residential settings are based solely on service costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ Nominal deductible
- ☐ Coinsurance
- ☐ Co-Payment
- ☐ Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

☒ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

☐ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	6652.34	5996.58	12648.92	37158.30	11413.50	48571.80	35922.88
2	6788.67	6296.41	13085.08	39016.22	11984.18	51000.40	37915.32
3	6921.00	6611.23	13532.23	40967.03	12583.38	53550.41	40018.18
4	7060.48	6941.79	14002.27	43015.38	13212.55	56227.93	42225.66
5	7200.98	7288.88	14489.86	45166.15	13873.18	59039.33	44549.47

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	12237		12237
Year 2	12237		12237
Year 3	12237		12237
Year 4	12237		12237
Year 5	12237		12237

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (2 of 9)**

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is expected to remain the same throughout the five years of the waiver. The ALOS days were based on the 08/01/15 - 07/31/16 372 reports that incorporated historical ALOS back to 08/01/13.

The CMS 372 reports used to develop and report ALOS is August 1, 2015 - July 31, 2016.

Unduplicated participants were trended based on assumption provided by the State's actuary. Lapse rates were included in the assumption calculations provided by the actuary.

Total unduplicated number of members were trended to remain the same throughout the five years of the waiver. Unduplicated members were based on the assumptions provided by the actuary and historical trends.

Limitation on the Number of Participants Served at any Point in Time were projected to remain the same each year based on historical growth and average monthly costs per recipient on the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is not impacted by changes in population. However, Factor D is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D was adjusted due to the transition to managed care. In this submission, the post-managed care values were increased by 2% each waiver year. The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

The 2% increase is trended based on the assumptions provided by the actuary and historical trends.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is not impacted by changes in population. However, Factor D' is impacted by the transition from a fee-for-service program to a managed care capitation rate program. In the prior waiver period, Factor D' was adjusted due to the transition to managed care. In this submission, the post-managed care values were increased by 5% each waiver year. The number of unduplicated participants reflects the managed care program's incentive to move individuals from the institutional setting to the HCBS waiver community setting.

Factor D' projections were based on assumptions provided by the State's actuary.

The 5% increase is trended based on the assumptions provided by the actuary and historical trends.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The state date of the MSIS reports used to develop the projections for Factor G and Factor G' was November 1, 2014. The annual CMS 372 reports that the State submits are based on MMIS reports. Also, Factor G and G' projections are based on assumptions provided by the State's actuary.

The historical data used in the Factor G and G' projections are based on assumptions provided by the State's actuary. These assumptions are based on historical data going back to 2012.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on MSIS reports through July 31, 2016, Factor G' projections were increased by 5% per year based on historical data and on assumptions provided by the State's actuary. The CMS 372 reports the State files annually are based on MMIS reports.

The state date of the MSIS reports used to develop the projections for Factor G and Factor G' was November 1, 2014. The annual CMS 372 reports that the State submits are based on MMIS reports. Also, Factor G and G' projections are based on assumptions provided by the State's actuary.

The historical data used in the Factor G and G' projections are based on assumptions provided by the State's actuary. These assumptions are based on historical data going back to 2012.

The change in the number of lives does not have any influence over the calculation of Factor G and/or Factor G'. These are established from historical data and have been maintained from the prior waiver amendment

filings. Factor G' was carried forward without adjustment from the prior 1915(c) waiver filing. The percentage increase for Factor G' is derived from historical Iowa Medicaid cost trends.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Homemaker	
Respite	
Home Health Aide Services	
Nursing Services	
Financial Management Service	
Assisted Living	
Assistive Devices	
Chore Services	
Consumer Directed Attendant Care-unskilled	
Consumer-directed attendant care - Skilled	
Home and Vehicle Modification	
Home Delivered Meals	
Independant Support Brokerage Service	
Individual Directed Goods and Services	
Mental Health Outreach	
Nutritional Counseling	
Personal Emergency Response or Portable Locator System	
Self Directed Community Support and Employment	
Self-directed Personal Care	
Senior Companion	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							939203.81
Adult Day Care-Extended Day	<input checked="" type="checkbox"/>	Day	5	66.80	71.31	23817.54	
adult day care- 15 minutes	<input checked="" type="checkbox"/>	15 Minutes	4	775.04	1.92	5952.31	
Adult Day Care-Full Day	<input checked="" type="checkbox"/>	Day	235	60.57	56.60	805641.57	
Adult Day Care-Half Day	<input checked="" type="checkbox"/>	Half Day	70	48.44	30.61	103792.39	
Case Management Total:							13173921.49
Case Management	<input checked="" type="checkbox"/>	up to 15 minutes	11666	44.06	25.63	13173921.49	
Homemaker Total:							6652836.83
Homemaker	<input checked="" type="checkbox"/>	15 minutes	3712	83.09	21.57	6652836.83	
Respite Total:							472664.28
Respite-FIHA Basic	<input checked="" type="checkbox"/>	15 minutes	99	98.75	25.48	249098.85	
Respite-Facility Nursing Facility	<input checked="" type="checkbox"/>	15 minutes	1	283.00	3.68	1041.44	
Respite-Home Care Agency Basic	<input checked="" type="checkbox"/>	15 minutes	60	137.72	18.32	151381.82	
Respite-HHA Specialized	<input checked="" type="checkbox"/>	Hour	10	88.30	33.82	29863.06	
Respite-Home Care Agency Group	<input checked="" type="checkbox"/>	15 minutes	10	262.60	13.96	36658.96	
Respite-Facility Hospital/Skilled	<input checked="" type="checkbox"/>	15 minutes	3	39.00	8.95	1047.15	
Respite-Home Care Agency Specialized	<input checked="" type="checkbox"/>	15 minutes	3	60.00	19.85	3573.00	
Home Health Aide Services Total:							113274.58
Home Health Aide Services	<input checked="" type="checkbox"/>	Visit	38	86.73	34.37	113274.58	
Nursing Services Total:							81505.34
Nursing Care Services-RN, Per Visit	<input checked="" type="checkbox"/>	Visit	34	12.76	88.56	38420.87	
Nursing Care Services-LPN, Per Visit	<input checked="" type="checkbox"/>	Visit	5	182.60	47.19	43084.47	
GRAND TOTAL:							81404703.91
Total: Services included in capitation:							81404703.91
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6652.34
Services included in capitation:							6652.34
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Service Total:							167872.68
Financial Management Service	<input checked="" type="checkbox"/>	Month	353	12.00	39.63	167872.68	
Assisted Living Total:							6218299.22
Assisted Living	<input checked="" type="checkbox"/>	Day	1180	217.13	24.27	6218299.22	
Assistive Devices Total:							32373.34
Assistive Devices	<input checked="" type="checkbox"/>	Unit	482	3.14	21.39	32373.34	
Chore Services Total:							1144648.29
Chore Services	<input checked="" type="checkbox"/>	15 minutes	1103	123.69	8.39	1144648.29	
Consumer Directed Attendant Care- unskilled Total:							30262901.03
CDAC-Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	3135	2181.00	3.25	22221663.75	
CDAC-Agency- Monthly	<input type="checkbox"/>	Monthly	0	0.00	0.01	0.00	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	1933	774.67	5.37	8041237.28	
Consumer-directed attendant care - Skilled Total:							3361365.09
CDAC- Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	348	175.34	40.43	2466970.68	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	215	1.33	3127.80	894394.41	
Home and Vehicle Modification Total:							163495.38
Home and Vehicle Modification	<input checked="" type="checkbox"/>	Job	596	130.01	2.11	163495.38	
Home Delivered Meals Total:							13844455.20
Morning Meal	<input checked="" type="checkbox"/>	Meal	675	133.43	7.41	667383.50	
Liquid Supplement Meal	<input checked="" type="checkbox"/>	Mcal	1878	130.01	4.14	1010817.35	
Noon Meal	<input checked="" type="checkbox"/>	Meal	6057	175.34	7.46	7922776.47	
Evening Meal	<input checked="" type="checkbox"/>	Meal	3292	163.79	7.87	4243477.87	
GRAND TOTAL:							81404703.91
Total: Services included in capitation:							81404703.91
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6652.34
Services included in capitation:							6652.34
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Support Brokerage Service Total:							29694.36
Independent Support Brokerage Service	<input checked="" type="checkbox"/>	hour	353	12.00	7.01	29694.36	
Individual Directed Goods and Services Total:							95564.16
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	Month	353	12.00	22.56	95564.16	
Mental Health Outreach Total:							252284.66
Mental Health Outreach	<input checked="" type="checkbox"/>	15 minute	222	48.42	23.47	252284.66	
Nutritional Counseling Total:							235.30
Nutritional Counseling	<input checked="" type="checkbox"/>	15 minute	4	6.50	9.05	235.30	
Personal Emergency Response or Portable Locator System Total:							1939503.54
Personal Emergency Response-Initial	<input checked="" type="checkbox"/>	Installation	664	1.00	44.63	29634.32	
Personal Emergency Response-Ongoing	<input checked="" type="checkbox"/>	Month	6647	8.76	32.80	1909869.22	
Self Directed Community Support and Employment Total:							234716.76
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	Month	353	12.00	55.41	234716.76	
Self-directed Personal Care Total:							973517.52
Self-directed Personal Care	<input checked="" type="checkbox"/>	Month	353	12.00	229.82	973517.52	
Senior Companion Total:							8813.22
Senior Companion	<input checked="" type="checkbox"/>	15 minutes	15	82.87	7.09	8813.22	
Transportation Total:							1241557.84
Transportation, per mile	<input checked="" type="checkbox"/>	mile	8	1244.63	0.31	3086.68	
Transportation: per trip	<input checked="" type="checkbox"/>	trip	1495	67.46	12.28	1238471.16	
GRAND TOTAL:							81404703.91
Total: Services included in capitation:							81404703.91
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6652.34
Services included in capitation:							6652.34
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							957958.18
Adult Day Care-Extended Day	<input checked="" type="checkbox"/>	Day	5	66.80	72.74	24295.16	
adult day care- 15 minutes	<input checked="" type="checkbox"/>	15 minutes	4	775.04	1.96	6076.31	
Adult Day Care-Full Day	<input checked="" type="checkbox"/>	Day	235	60.57	57.73	821725.93	
Adult Day Care-Half Day	<input checked="" type="checkbox"/>	Half Day	70	48.44	31.22	105860.78	
Case Management Total:							13436063.51
Case Management	<input checked="" type="checkbox"/>	up to 15 Minutes	11666	44.06	26.14	13436063.51	
Homemaker Total:							6785461.76
Homemaker	<input checked="" type="checkbox"/>	15 minutes	3712	83.09	22.00	6785461.76	
Respite Total:							482167.40
Respite-HHA Basic	<input checked="" type="checkbox"/>	15 minutes	99	98.75	25.99	254084.74	
Respite-Facility Nursing Facility	<input checked="" type="checkbox"/>	15 minutes	1	286.00	3.75	1072.50	
Respite-Home Care Agency Basic	<input checked="" type="checkbox"/>	15 minutes	60	137.72	18.69	154439.21	
Respite-HHA Specialized	<input checked="" type="checkbox"/>	15 minutes	10	88.30	34.50	30463.50	
Respite-Home Care Agency Group	<input checked="" type="checkbox"/>	15 minutes	10	262.60	14.24	37394.24	
Respite-Facility Hospital/Skilled	<input checked="" type="checkbox"/>	15 minutes	3	39.00	9.13	1068.21	
	<input checked="" type="checkbox"/>	15 minutes				3645.00	
GRAND TOTAL:						83072986.05	
Total: Services included in capitation:						83072986.05	
Total: Services not included in capitation:						0.00	
Total Estimated Unduplicated Participants:						12237	
Factor D (Divide total by number of participants):						6788.67	
Services included in capitation:						6788.67	
Services not included in capitation:						0.00	
Average Length of Stay on the Waiver:						280	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
Respite-Home Care Agency Specialized			3	60.00	20.25		
Home Health Aide Services Total:							115548.64
Home Health Aide Services	<input checked="" type="checkbox"/>	Visit	38	86.73	35.06	115548.64	
Nursing Services Total:							83131.46
Nursing Care Services-RN, Per Visit	<input checked="" type="checkbox"/>	Visit	34	12.76	90.33	39188.77	
Nursing Care Services-LPN, Per Visit	<input checked="" type="checkbox"/>	Visit	5	182.60	48.13	43942.69	
Financial Management Service Total:							171219.12
Financial Management Service	<input checked="" type="checkbox"/>	Month	353	12.00	40.42	171219.12	
Assisted Living Total:							6343843.78
Assisted Living	<input checked="" type="checkbox"/>	Day	1180	217.13	24.76	6343843.78	
Assistive Devices Total:							33024.13
Assistive Devices	<input checked="" type="checkbox"/>	Unit	482	3.14	21.82	33024.13	
Chore Services Total:							1167841.40
Chore Services	<input checked="" type="checkbox"/>	15 minutes	1103	123.69	8.56	1167841.40	
Consumer Directed Attendant Care- unskilled Total:							30906239.56
CDAC-Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	3135	2181.00	3.32	22700284.20	
CDAC-Agency- Monthly	<input type="checkbox"/>	Monthly	0	0.00	0.01	0.00	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	1933	774.67	5.48	8205955.36	
Consumer-directed attendant care - Skilled Total:							3428678.96
CDAC- Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	348	175.34	41.24	2516395.52	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	215	1.33	3190.36	912283.44	
Home and Vehicle Modification Total:							166594.81
GRAND TOTAL:							83072986.05
Total: Services included in capitation:							83072986.05
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6788.67
Services included in capitation:							6788.67
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home and Vehicle Modification	<input checked="" type="checkbox"/>	Job	596	130.01	2.15	166594.81	
Home Delivered Meals Total:							14123074.31
Morning Meal	<input checked="" type="checkbox"/>	Meal	675	133.43	7.56	680893.29	
Liquid Supplement Meal	<input checked="" type="checkbox"/>	Meal	1878	130.01	4.22	1030350.05	
Noon Meal	<input checked="" type="checkbox"/>	Meal	6057	175.34	7.61	8082081.63	
Evening Meal	<input checked="" type="checkbox"/>	Meal	3292	163.79	8.03	4329749.34	
Independant Support Brokerage Service Total:							30287.40
Independant Support Brokerage Service	<input checked="" type="checkbox"/>	hour	353	12.00	7.15	30287.40	
Individual Directed Goods and Services Total:							97470.36
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	Month	353	12.00	23.01	97470.36	
Mental Health Outreach Total:							257336.81
Mental Health Outreach	<input checked="" type="checkbox"/>	15 minutes	222	48.42	23.94	257336.81	
Nutritional Counseling Total:							239.98
Nutritional Counseling	<input checked="" type="checkbox"/>	15 minutes	4	6.50	9.23	239.98	
Personal Emergency Response or Portable Locator System Total:							1978524.79
Personal Emergency Response-Initial	<input checked="" type="checkbox"/>	Installation	664	1.00	45.52	30225.28	
Personal Emergency Response-Ongoing	<input checked="" type="checkbox"/>	Month	6647	8.76	33.46	1948299.51	
Self Directed Community Support and Employment Total:							239418.72
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	Month	353	12.00	56.52	239418.72	
Self-directed Personal Care Total:							993003.12
Self-directed Personal Care	<input checked="" type="checkbox"/>	Month	353	12.00	234.42	993003.12	
GRAND TOTAL:							83072986.05
Total: Services included in capitation:							83072986.05
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6788.67
Services included in capitation:							6788.67
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Senior Companion Total:							8987.25
Senior Companion	<input checked="" type="checkbox"/>	15 minutes	15	82.87	7.23	8987.25	
Transportation Total:							1266870.58
Transportation, per mile	<input checked="" type="checkbox"/>	mile	8	1244.63	0.32	3186.25	
Transportation: per trip	<input checked="" type="checkbox"/>	trip	1495	67.46	12.53	1263684.33	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							83072986.05 83072986.05 0.00 12237 6788.67 6788.67 0.00 280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							977214.08
Adult Day Care- Extended Day	<input checked="" type="checkbox"/>	Day	5	66.80	74.19	24779.46	
adult day care- 15 minutes	<input checked="" type="checkbox"/>	15 Minutes	4	775.04	2.00	6200.32	
Adult Day Care- Full Day	<input checked="" type="checkbox"/>	Day	235	60.57	58.89	838237.32	
Adult Day Care- Half Day	<input checked="" type="checkbox"/>	Half Day	70	48.44	31.85	107996.98	
Case Management Total:							13708485.61
Case Management						13708485.61	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							84692269.59 84692269.59 0.00 12237 6921.00 6921.00 0.00 280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input checked="" type="checkbox"/>	up to 15 Minutes	11666	44.06	26.67		
Homemaker Total:							6921171.00
Homemaker	<input checked="" type="checkbox"/>	15 minutes	3712	83.09	22.44	6921171.00	
Respite Total:							491754.60
Respite-HHA Basic	<input checked="" type="checkbox"/>	15 minutes	99	98.75	26.51	259168.39	
Respite-Facility Nursing Facility	<input checked="" type="checkbox"/>	15 minutes	1	283.00	3.82	1081.06	
Respite-Home Care Agency Basic	<input checked="" type="checkbox"/>	15 minutes	60	137.72	19.06	157496.59	
Respite-HHA Specialized	<input checked="" type="checkbox"/>	15 minutes	10	88.30	35.19	31072.77	
Respite-Home Care Agency Group	<input checked="" type="checkbox"/>	15 minutes	10	262.60	14.52	38129.52	
Respite-Facility Hospital/Skilled	<input checked="" type="checkbox"/>	15 minutes	3	39.00	9.31	1089.27	
Respite-Home Care Agency Specialized	<input checked="" type="checkbox"/>	15 minutes	3	60.00	20.65	3717.00	
Home Health Aide Services Total:							117855.66
Home Health Aide Services	<input checked="" type="checkbox"/>	Visit	38	86.73	35.76	117855.66	
Nursing Services Total:							84802.32
Nursing Care Services-RN, Per Visit	<input checked="" type="checkbox"/>	Visit	34	12.76	92.14	39974.02	
Nursing Care Services-LPN, Per Visit	<input checked="" type="checkbox"/>	Visit	5	182.60	49.10	44828.30	
Financial Management Service Total:							174650.28
Financial Management Service	<input checked="" type="checkbox"/>	Month	353	12.00	41.23	174650.28	
Assisted Living Total:							6469388.35
Assisted Living	<input checked="" type="checkbox"/>	Day	1180	217.13	25.25	6469388.35	
Assistive Devices Total:							33674.93
Assistive Devices	<input checked="" type="checkbox"/>	Unit	482	3.14	22.25	33674.93	
Chore Services Total:							1191034.51
GRAND TOTAL:							84692269.59
Total: Services included in capitation:							84692269.59
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6921.00
Services included in capitation:							6921.00
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Services	<input checked="" type="checkbox"/>	15 minutes	1103	123.69	8.73	1191034.51	
Consumer Directed Attendant Care-unskilled Total:							31481203.74
CDAC-Individual-15 minute	<input checked="" type="checkbox"/>	15 Minutes	3135	2181.00	3.38	23110530.30	
CDAC-Agency-Monthly	<input type="checkbox"/>	Monthly	0	0.00	0.01	0.00	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	1933	774.67	5.59	8370673.44	
Consumer-directed attendant care - Skilled Total:							3496957.59
CDAC- Individual-15 minute	<input checked="" type="checkbox"/>	15 Minutes	348	175.34	42.06	2566430.54	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	215	1.33	3254.16	930527.05	
Home and Vehicle Modification Total:							170469.11
Home and Vehicle Modification	<input checked="" type="checkbox"/>	Job	596	130.01	2.20	170469.11	
Home Delivered Meals Total:							14404135.02
Morning Meal	<input checked="" type="checkbox"/>	Meal	675	133.43	7.71	694403.08	
Liquid Supplement Meal	<input checked="" type="checkbox"/>	Meal	1878	130.01	4.31	1052324.34	
Noon Meal	<input checked="" type="checkbox"/>	Meal	6057	175.34	7.76	8241386.79	
Evening Meal	<input checked="" type="checkbox"/>	Meal	3292	163.79	8.19	4416020.81	
Independent Support Brokerage Service Total:							30880.44
Independent Support Brokerage Service	<input checked="" type="checkbox"/>	hour	353	12.00	7.29	30880.44	
Individual Directed Goods and Services Total:							99418.92
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	Month	353	12.00	23.47	99418.92	
Mental Health Outreach Total:							262496.44
Mental Health Outreach	<input checked="" type="checkbox"/>	15 minutes	222	48.42	24.42	262496.44	
Nutritional Counseling Total:							244.92
GRAND TOTAL:							84692269.59
Total: Services included in capitation:							84692269.59
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6921.00
Services included in capitation:							6921.00
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Counseling	<input checked="" type="checkbox"/>	15 minutes	4	6.50	9.42	244.92	
Personal Emergency Response or Portable Locator System Total:							2018141.60
Personal Emergency Response-Initial	<input checked="" type="checkbox"/>	Installation	664	1.00	46.43	30829.52	
Personal Emergency Response-Ongoing	<input checked="" type="checkbox"/>	Month	6647	8.76	34.13	1987312.08	
Self Directed Community Support and Employment Total:							244205.40
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	Month	353	12.00	57.65	244205.40	
Self-directed Personal Care Total:							1012827.60
Self-directed Personal Care	<input checked="" type="checkbox"/>	Month	353	12.00	239.10	1012827.60	
Senior Companion Total:							9173.71
Senior Companion	<input checked="" type="checkbox"/>	15 minutes	15	82.87	7.38	9173.71	
Transportation Total:							1292083.76
Transportation, per mile	<input checked="" type="checkbox"/>	mile	8	1244.63	0.32	3186.25	
Transportation: per trip	<input checked="" type="checkbox"/>	trip	1495	67.46	12.78	1288897.51	
GRAND TOTAL:							84692269.59
Total: Services included in capitation:							84692269.59
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							6921.00
Services included in capitation:							6921.00
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							996622.33
Adult Day Care-Extended Day	<input checked="" type="checkbox"/>	Day	5	66.80	75.67	25273.78	
adult day care- 15 minutes	<input checked="" type="checkbox"/>	15 Minutes	4	775.04	2.04	6324.33	
Adult Day Care-Full Day	<input checked="" type="checkbox"/>	Day	235	60.57	60.06	854891.04	
Adult Day Care-Half Day	<input checked="" type="checkbox"/>	Half Day	70	48.44	32.48	110133.18	
Case Management Total:							13980907.71
Case Management	<input checked="" type="checkbox"/>	up to 15 Minutes	11666	44.06	27.20	13980907.71	
Homemaker Total:							7059964.53
Homemaker	<input checked="" type="checkbox"/>	15 minutes	3712	83.09	22.89	7059964.53	
Respite Total:							501577.17
Respite-HHA Basic	<input checked="" type="checkbox"/>	15 minutes	99	98.75	27.04	264349.80	
Respite-Facility Nursing Facility	<input checked="" type="checkbox"/>	15 minutes	1	283.00	3.91	1106.53	
Respite-Home Care Agency Basic	<input checked="" type="checkbox"/>	15 minutes	60	137.72	19.44	160636.61	
Respite-HHA Specialized	<input checked="" type="checkbox"/>	15 minutes	10	88.30	35.89	31690.87	
Respite-Home Care Agency Group	<input checked="" type="checkbox"/>	15 minutes	10	262.60	14.81	38891.06	
Respite-Facility Hospital/Skilled	<input checked="" type="checkbox"/>	15 minutes	3	39.00	9.50	1111.50	
Respite-Home Care Agency Specialized	<input checked="" type="checkbox"/>	15 minutes	3	60.00	21.06	3790.80	
Home Health Aide Services Total:							120195.64
Home Health Aide Services	<input checked="" type="checkbox"/>	Visit	38	86.73	36.47	120195.64	
Nursing Services Total:							86495.32
Nursing Care Services-RN, Per Visit	<input checked="" type="checkbox"/>	Visit	34	12.76	93.98	40772.28	
Nursing Care Services-LPN, Per Visit	<input checked="" type="checkbox"/>	Visit	5	182.60	50.08	45723.04	
GRAND TOTAL:							86399112.33
Total: Services included in capitation:							86399112.33
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7060.48
Services included in capitation:							7060.48
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Service Total:							178166.16
Financial Management Service	<input checked="" type="checkbox"/>	Month	353	12.00	42.06	178166.16	
Assisted Living Total:							6600057.18
Assisted Living	<input checked="" type="checkbox"/>	Day	1180	217.13	25.76	6600057.18	
Assistive Devices Total:							34356.00
Assistive Devices	<input checked="" type="checkbox"/>	Unit	482	3.14	22.70	34356.00	
Chore Services Total:							1214227.62
Chore Services	<input checked="" type="checkbox"/>	15 minutes	1103	123.69	8.90	1214227.62	
Consumer Directed Attendant Care-unskilled Total:							32124542.28
CDAC-Individual-15 minute	<input checked="" type="checkbox"/>	15 Minutes	3135	2181.00	3.45	23589150.75	
CDAC-Agency-Monthly	<input type="checkbox"/>	Monthly	0	0.00	0.01	0.00	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	1933	774.67	5.70	8535391.53	
Consumer-directed attendant care - Skilled Total:							3566825.47
CDAC- Individual-15 minute	<input checked="" type="checkbox"/>	15 Minutes	348	175.34	42.90	2617685.93	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	215	1.33	3319.25	949139.54	
Home and Vehicle Modification Total:							173568.55
Home and Vehicle Modification	<input checked="" type="checkbox"/>	Job	596	130.01	2.24	173568.55	
Home Delivered Meals Total:							14693374.48
Morning Meal	<input checked="" type="checkbox"/>	Meal	675	133.43	7.86	707912.86	
Liquid Supplement Meal	<input checked="" type="checkbox"/>	Meal	1878	130.01	4.39	1071857.04	
Noon Meal	<input checked="" type="checkbox"/>	Meal	6057	175.34	7.92	8411312.29	
Evening Meal	<input checked="" type="checkbox"/>	Meal	3292	163.79	8.35	4502292.28	
GRAND TOTAL:							86399112.33
Total: Services included in capitation:							86399112.33
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7060.48
Services included in capitation:							7060.48
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Support Brokerage Service Total:							31515.84
Independent Support Brokerage Service	<input checked="" type="checkbox"/>	hour	353	12.00	7.44	31515.84	
Individual Directed Goods and Services Total:							101409.84
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	Month	353	12.00	23.94	101409.84	
Mental Health Outreach Total:							267763.57
Mental Health Outreach	<input checked="" type="checkbox"/>	15 minutes	222	48.42	24.91	267763.57	
Nutritional Counseling Total:							249.60
Nutritional Counseling	<input checked="" type="checkbox"/>	15 minutes	4	6.50	9.60	249.60	
Personal Emergency Response or Portable Locator System Total:							2058353.97
Personal Emergency Response-Initial	<input checked="" type="checkbox"/>	Installation	664	1.00	47.36	31447.04	
Personal Emergency Response-Ongoing	<input checked="" type="checkbox"/>	Month	6647	8.76	34.81	2026906.93	
Self Directed Community Support and Employment Total:							249076.80
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	Month	353	12.00	58.80	249076.80	
Self-directed Personal Care Total:							1033118.04
Self-directed Personal Care	<input checked="" type="checkbox"/>	Month	353	12.00	243.89	1033118.04	
Senior Companion Total:							9347.74
Senior Companion	<input checked="" type="checkbox"/>	15 minutes	15	82.87	7.52	9347.74	
Transportation Total:							1317396.50
Transportation, per mile	<input checked="" type="checkbox"/>	mile	8	1244.63	0.33	3285.82	
Transportation, per trip	<input checked="" type="checkbox"/>	trip	1495	67.46	13.03	1314110.68	
GRAND TOTAL:							86399112.33
Total: Services included in capitation:							86399112.33
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7060.48
Services included in capitation:							7060.48
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							1016681.11
Adult Day Care-Extended Day	<input checked="" type="checkbox"/>	Day	5	66.80	77.19	25781.46	
adult day care- 15 minutes	<input checked="" type="checkbox"/>	15 Minutes	4	775.04	2.08	6448.33	
Adult Day Care-Full Day	<input checked="" type="checkbox"/>	Day	235	60.57	61.27	872114.12	
Adult Day Care-Half Day	<input checked="" type="checkbox"/>	Half Day	70	48.44	33.13	112337.20	
Case Management Total:							14258469.85
Case Management	<input checked="" type="checkbox"/>	up to 15 Minutes	11666	44.06	27.74	14258469.85	
Homemaker Total:							7201842.37
Homemaker	<input checked="" type="checkbox"/>	15 minutes	3712	83.09	23.35	7201842.37	
Respite Total:							511621.99
Respite-HHA Basic	<input checked="" type="checkbox"/>	15 minutes	99	98.75	27.58	269628.98	
Respite-Facility Nursing Facility	<input checked="" type="checkbox"/>	15 minutes	1	283.00	3.98	1126.34	
Respite-Home Care Agency Basic	<input checked="" type="checkbox"/>	15 minutes	60	137.72	19.83	163859.26	
Respite-HHA Specialized	<input checked="" type="checkbox"/>	15 minutes	10	88.30	36.61	32326.63	
Respite-Home Care Agency Group	<input checked="" type="checkbox"/>	15 minutes	10	262.60	15.11	39678.86	
Respite-Facility Hospital/Skilled	<input checked="" type="checkbox"/>	15 minutes	3	39.00	9.69	1133.73	
	<input checked="" type="checkbox"/>	15 minutes				3868.20	
GRAND TOTAL:							88118388.85
Total: Services included in capitation:							88118388.85
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7200.98
Services included in capitation:							7200.98
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite-Home Care Agency Specialized			3	60.00	21.49		
Home Health Aide Services Total:							122601.53
Home Health Aide Services	<input checked="" type="checkbox"/>	Visit	38	86.73	37.20	122601.53	
Nursing Services Total:							88223.94
Nursing Care Services-RN, Per Visit	<input checked="" type="checkbox"/>	Visit	34	12.76	95.86	41587.90	
Nursing Care Services-LPN, Per Visit	<input checked="" type="checkbox"/>	Visit	5	182.60	51.08	46636.04	
Financial Management Service Total:							181724.40
Financial Management Service	<input checked="" type="checkbox"/>	Month	353	12.00	42.90	181724.40	
Assisted Living Total:							6730726.02
Assisted Living	<input checked="" type="checkbox"/>	Day	1180	217.13	26.27	6730726.02	
Assistive Devices Total:							35037.06
Assistive Devices	<input checked="" type="checkbox"/>	Unit	482	3.14	23.15	35037.06	
Chore Services Total:							1238785.04
Chore Services	<input checked="" type="checkbox"/>	15 minutes	1103	123.69	9.08	1238785.04	
Consumer Directed Attendant Care- unskilled Total:							32767880.81
CDAC-Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	3135	2181.00	3.52	24067771.20	
CDAC-Agency- Monthly	<input type="checkbox"/>	Monthly	0	0.00	0.01	0.00	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	1933	774.67	5.81	8700109.61	
Consumer-directed attendant care - Skilled Total:							3638282.58
CDAC- Individual- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	348	175.34	43.76	2670161.68	
CDAC-Agency- 15 minute	<input checked="" type="checkbox"/>	15 Minutes	215	1.33	3385.63	968120.90	
Home and Vehicle Modification Total:							176667.99
GRAND TOTAL:							88118388.85
Total: Services included in capitation:							88118388.85
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7200.98
Services included in capitation:							7200.98
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home and Vehicle Modification	<input checked="" type="checkbox"/>	Job	596	130.01	2.28	176667.99	
Home Delivered Meals Total:							14980727.80
Morning Meal	<input checked="" type="checkbox"/>	Meal	675	133.43	8.02	722323.30	
Liquid Supplement Meal	<input checked="" type="checkbox"/>	Meal	1878	130.01	4.48	1093831.33	
Noon Meal	<input checked="" type="checkbox"/>	Meal	6057	175.34	8.07	8570617.45	
Evening Meal	<input checked="" type="checkbox"/>	Meal	3292	163.79	8.52	4593955.71	
Independant Support Brokerage Service Total:							32151.24
Independant Support Brokerage Service	<input checked="" type="checkbox"/>	hour	353	12.00	7.59	32151.24	
Individual Directed Goods and Services Total:							103443.12
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	Month	353	12.00	24.42	103443.12	
Mental Health Outreach Total:							273030.70
Mental Health Outreach	<input checked="" type="checkbox"/>	15 Minutes	222	48.42	25.40	273030.70	
Nutritional Counseling Total:							254.80
Nutritional Counseling	<input checked="" type="checkbox"/>	15 Minutes	4	6.50	9.80	254.80	
Personal Emergency Response or Portable Locator System Total:							2099161.90
Personal Emergency Response-Initial	<input checked="" type="checkbox"/>	Installation	664	1.00	48.31	32077.84	
Personal Emergency Response-Ongoing	<input checked="" type="checkbox"/>	Month	6647	8.76	35.50	2067084.06	
Self Directed Community Support and Employment Total:							254075.28
Self Directed Community Support and Employment	<input checked="" type="checkbox"/>	Month	353	12.00	59.98	254075.28	
Self-directed Personal Care Total:							1053747.36
Self-directed Personal Care	<input checked="" type="checkbox"/>	month	353	12.00	248.76	1053747.36	
GRAND TOTAL:							88118388.85
Total: Services included in capitation:							88118388.85
Total: Services not included in capitation:							0.00
Total Estimated Unduplicated Participants:							12237
Factor D (Divide total by number of participants):							7200.98
Services included in capitation:							7200.98
Services not included in capitation:							0.00
Average Length of Stay on the Waiver:							280

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Senior Companion Total:							9534.19
Senior Companion	<input checked="" type="checkbox"/>	15 minutes	15	82.87	7.67	9534.19	
Transportation Total:							1343717.78
Transportation, per mile	<input checked="" type="checkbox"/>	mile	8	1244.63	0.34	3385.39	
Transportation: per trip	<input checked="" type="checkbox"/>	trip	1495	67.46	13.29	1340332.38	
GRAND TOTAL:						88118388.85	
Total: Services included in capitation:						88118388.85	
Total: Services not included in capitation:						0.00	
Total Estimated Unduplicated Participants:						12237	
Factor D (Divide total by number of participants):						7200.98	
Services included in capitation:						7200.98	
Services not included in capitation:						0.00	
Average Length of Stay on the Waiver:							280

Appendix A: Waiver Administration and Operation**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO performance monitoring

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO performance monitoring

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Entity and MCOs	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LC-a1: IME will measure the number and percent of approved LOC decisions.

Numerator: # of completed LOC; Denominator: # of referrals for LOC.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO populations.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: contracted entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IME MQUIDS and OnBase

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards.

Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-a1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-Assurance:** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- c. **Sub-Assurance:** *The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.

All MCO providers must be enrolled as verified by IME Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: contracted entity and MCO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-a: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-c2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/>	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Medicaid contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

SP-cl1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-d1: The IME will measure the # and percent of members' service plans that identify all the following elements: * amount, duration, and funding sources of all services * all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Service plans are requested from the case managers, with service provision documentation requested from providers

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-el: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who stated that they were a part of planning their services; Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

FFS HCBS UNIT QA survey data and MCO IPES databases

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers.
Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; **Denominator:** The total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

FFS QA review of service plan stored in OnBase. MCOs review service plans available through their systems.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medical Services unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Medical Services unit utilized criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect case manager remediation request response is in development.

The HCBS unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCOs	<input type="checkbox"/> Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. **Sub-Assurances:**

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-a1: The IME will measure the total number and percent of IAC-defined major critical incidents requiring follow-up escalation that were investigated.

Numerator = # of critical incidents that received follow-up as required;

Denominator = # of critical incidents requiring follow-up escalation

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Data collected in the FFS and MCO CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

HW-a2: The IME will measure CIs that identify a reportable event of abuse, neglect, exploitation, or unexplained death and were followed upon appropriately. Numerator = # of CIRs that identified a report was made to DHS protective services and/or appropriate follow up was initiated; Denominator = # of CIs that identified a reportable event of abuse, neglect, exploitation, and/or unexplained death

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

FFS and MCO CIR databases

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-b1: The IME will identify all unresolved critical incidents which resulted in a targeted review and were completed to resolution. Numerator = # of targeted reviews resulting from an incident which were resolved within 60 days;
Denominator = # of critical incidents that resulted in a targeted review.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

FFS/HCBS Unit and MCO data obtained from CIR databases.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-cl: The IME will measure the total # and % of providers with policies for restrictive measures that are consistent with State and Federal policy and rules,

and followed as written. Numerator = # providers reviewed that have policies for restrictive measures that were implemented as written; Denominator = total # of providers reviewed that identified having policies for restrictive measures.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider's policies and procedures. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-d1: The IME will measure the number and percent of providers meeting state and federal requirements relative to individual waivers. Numerator = # of Quality Assurance reviews that did not receive a corrective action plan; Denominator = # of provider Quality Assurance Reviews completed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

All QA reviews that don't result in a corrective action. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: Contracted Entity including MCO		Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The HCBS Quality Assurance unit and each MCO is responsible for monitoring and analyzing data associated with the major incidents reported for members on waivers. Data is pulled from the data warehouse and from MCO reporting on a regular basis for programmatic trends, individual issues and operational concerns. Reported incidents of abuse, medication error, death, rights restrictions, and restraints are investigated further by the HCBS Incident Reporting Specialist as each report is received. The analysis of this data is presented to the state on a quarterly basis.

The HCBS provider oversight unit, and each MCO, is responsible for conducting IPES interviews with waiver members. The IPES tool has been expanded based on the federal PES tool and thought to capture a more comprehensive view of Iowa's waiver population needs and issues. The IPES tool incorporates the seven principles of the Quality Framework and is able to adjust based on the member interviewed and service enrollment. HCBS Specialists conduct interviews either face-to-face or via telephone, to the discretion of the waiver member. All waiver members have the right to decline interview. The results of these interviews are presented to the state on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The HCBS Incident Reporting Specialist and each MCO analyzes data for individual and systemic issues. Individual issues require communication with the case manager to document all efforts to remediate risk or concern. If a these efforts are not successful, staff continues efforts to communicate with the case manager, the case manager's supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports.

The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response occurs, the Specialist first seeks further clarification from the member and provides education when necessary. Following the interview, the case manager is notified and information regarding remediation is required within 30 days. This data is stored in a database and reported to the state on a quarterly and annual basis. MCO are responsible for research and follow up to flagged responses.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes to provider policy.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: contracted entity and MCO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ☒ No
☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability**Quality Improvement: Financial Accountability**

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance:**

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. **Sub-Assurances:**

- a. *Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-a1: The IME will determine the number and percent of FFS reviewed claims supported by provider documentation. Numerator = # of reviewed paid claims where documents supports the units of service; Denominator = # of reviewed paid claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Program Integrity reviews claims and provider documentation for providers already under review.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
		<input checked="" type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: Annually a sample of claims from the 2 most utilized codes in the first year. Remaining codes are reviewed in following years. Documentation is reviewed to determine appropriate units.
	<input checked="" type="checkbox"/> Other Specify: quarterly across all waivers, annually for this waiver	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: quarterly across all waivers, annually for this waiver.

Performance Measure:

FA-a2: The IME will determine the number of clean claims that are paid by the managed care organizations within the time frames specified in the contract. Numerator = # of clean claims that are paid by the managed care organization within the time frames specified in the contract; Denominator = # of Managed Care provider claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Adjudicated claims summary, claims aging summary, and claims lag report

Responsible Party for data	Sampling Approach (check each that applies):
----------------------------	--

collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity including MCOs	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-b1: The IME will measure the number and percent of claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for waiver services provided. Numerator = # of reviewed claims paid using IME-approved rate methodologies; Denominator = # of reviewed paid claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The DW Unit query pulls paid claims data for all seven of the HCBS waivers.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

FA-b2: The IME will measure the number of capitation payments to the MCOs that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of Capitation payments made to the MCOs at the approved rates through the CMS certified MMIS. Denominator: # of capitation payments made through the CMS certified MMIS.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: contracted entity	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Program Integrity unit samples provider claims each quarter for quality. These claims are cross-walked with service documentation to determine the percentage of error associated with coding and documentation. This data is reported on a quarterly basis.

MCO claims data is compared to the contractual obligations for MCO timeliness of clean claim payments. Data is provided to the HCBS staff as well as to the Bureau of Managed Care.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When the Program Integrity unit discovers situations where providers are missing documentation to support billing or coded incorrectly, monies are recouped and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments; require screening of all claims, referral to MFCU, or provider suspension.

The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a quarterly basis.

If during the review of capitation payments the IME determines that a capitation was made in error, that claim is adjusted to create a corrected payment.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ☒ No
☐ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The IME is the single state agency that retains administrative authority of Iowa's HCBS Waivers. Iowa remains highly committed to continually improve the quality of services for all waiver programs. The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed. The QIS developed by Iowa stratifies all 1915(c) waivers:

IA.0213, HCBS AIDS/HIV
 IA.0242, HCBS Intellectual Disability
 IA.0299, HCBS Brain Injury
 IA.0345, HCBS Physical Disability
 IA.0819, HCBS Children's Mental Health
 IA.4111, HCBS Health and Disability
 IA.4155, HCBS Elderly

DHS also provides §1915(i) services and strives to maintain consistency in QIS between these and the State's §1915(c) waivers.

Based on contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and

prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to State or contract staff.

Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a monthly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level. ISIS will only be utilized for fee-for-service members.

All contracted MCOs are accountable for improving quality outcomes and developing a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major service delivery areas. The QM/QI program must have objectives that are measurable, realistic and supported by consensus among the MCOs' medical and quality improvement staff. Through the QM/QI program, the MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QM/QI program, the MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. Finally, MCOs must meet the requirements of 42 CFR 438 Subpart E and the standards of the credentialing body by which the MCO is credentialed in development of its QM/QI program. The State retains final authority to approve the MCOs' QM/QI program. The State has developed a draft-reporting manual for the MCOs to utilize for many of the managed care contract reporting requirements, including HCBS performance measures. The managed care contract also allows for the State to request additional regular and ad hoc reports.

Iowa acknowledges that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The State acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

The IME supports infrastructure development that ensures choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency as less time is spent on service/funding allocation and more time is spent on care coordination and improvement. A comprehensive system of information and referrals ensures that all individuals are allowed fully informed choices prior to facility placement.

A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Many program integrity and ACA initiatives will assist in system improvements. These include improvements to provider screening at enrollment, tighter sanction rules, and more emphasis on sustaining quality practices.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: Contracted Entity (Including MCOs)	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The IME has hired a Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The QA Manager and State policy staff address oversight of design changes and the subsequent monitoring and analysis during the weekly policy and monthly quality assurance meetings. Prior to dramatic system design changes, the State will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out to all relevant parties prior to implementation with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the DHS computer server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.

Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as State staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including but not limited to waiver services. Based on these analyses, recommendations for changes in policy are made to the IME policy staff and bureau chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations, and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

In addition to developing QM/QI programs that include regular, ongoing assessment of services provided to Medicaid beneficiaries, MCOs must maintain a QM/QI Committee that includes medical, behavioral health, and long-term care staff, and network providers. This committee is responsible for analyzing and evaluating the result of QM/QI activities, recommending policy decisions, ensuring that providers are involved in the QM/QI program, instituting needed action, and ensuring appropriate follow-up. This committee is also responsible for reviewing and approving the MCOs' QM/QI program description, annual evaluation, and associated work plan prior to submission to DHS.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.

In accordance with 42 CFR 438 Subpart E, the State will maintain a written strategy for assessing and improving the quality of services offered by MCOs including, but not limited to, an external independent review of the quality of, timeliness of, and access to services provided to Medicaid beneficiaries. MCOs must comply with the standards established by the State and must provide all information and reporting necessary for the State to carry out its obligations for the State quality strategy. MCOs are contractually required to ensure that the results of each external independent review are available to participating health care providers, members, and potential members of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient. Further, MCOs must establish stakeholder advisory boards that advise and provide input into: (a) service delivery; (b) quality of care; (c) member rights and responsibilities; (d) resolution of grievances and appeals; (e) operational issues; (f) program monitoring and evaluation; (g) member and provider education; and (h) priority issues identified by

members. In accordance with 42 CFR 438 Subpart E, the State will regularly monitor and evaluate the MCOs' compliance with the standards established in the State's quality strategy and the MCOs' QM/QI program. The State is in the process of developing specific processes and timelines to report results to agencies, waiver providers, participants, families, other interested parties and the public. This will include strategies such as leveraging the Medical Assistance Advisory Council (MAAC).

The HCBS Quality Assurance Unit (QAU) completes review of HCBS enrolled providers on a three-five year cycle. During the onsite review HCBS ensures personnel are trained in:

- Abuse reporting
- Incident reporting
- Have current mandatory reporter training
- Individual member support needs
- Rights restrictions
- Provision of member medication

In addition HCBS QAU reviews the centralized incident report file, appeals and grievances, and any allegations of abuse. During the review of service documentation any incident identified in narrative which falls under the Incident description in 77.25(3), is required to have an incident report filed. The agencies tracking and trending of incident reports is also reviewed during the onsite review. Any areas the agency may be out of compliance in results in the requirement of a corrective action plan. HCBS gives the provider 30 days to submit a time limited corrective action plan which will remediate the deficiency. 45 days after the corrective action plan has been accepted HCBS follows up and requires the agency to submit evidence that the corrective action plan was put into place.